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Reader's Guide

Many of you have suggested that it would be very helpful if the biographical data regarding our authors were condensed into a brief line or two, and appended on the article page itself. That change will be instituted with the January, 1948, issue. This page will still be included to draw your attention to specially featured articles but its function and material will be altered somewhat, henceforth. We want to share with you here some of the nice things people say about the *Journal*, some of the problems they raise, some of the questions they ask. For instance, this paragraph from a letter we received in September gave us quite a lift:

"I stayed in bed Sunday morning intending to glance over the *Journal*, then start in on a new book. I did not put the *Journal* down till it was time to get ready for lunch. I am all agog now to attend the next I.C.N. Congress in Sweden in 1949. I suppose it is too early to have any estimate of cost?"

We are trying to get some information on probable costs of the trip to Sweden. Freighters seem the cheapest means of transportation so far, and even they are around five hundred dollars return. We will keep you posted but you had better start saving now!

You will enjoy reading **Dr. Athol Gordon's** consideration of "The Nurse in a Changing Age." Dr. Gordon is a veteran physician in Winnipeg who saw service in both world wars. He enthralled his audience at the annual banquet of the Manitoba Association of Registered Nurses when he delivered this address as guest speaker.

The Committee on Instruction of the Association of Nurses of the Province of Quebec has followed up the plea made in the article "Conflicting Ideas in Textbooks." (*The Canadian Nurse*, Sept. 1945). After consulting various authorities, they have produced under the name of **Clara Aitkenhead,** who until recently was an instructor at Homoeopathic Hospital, Montreal, a very workable and effective guide which might well be written into the service manuals in all hospitals in Canada. This group is to be congratulated on the valuable contribution they have made to the problems of *isolation* techniques.

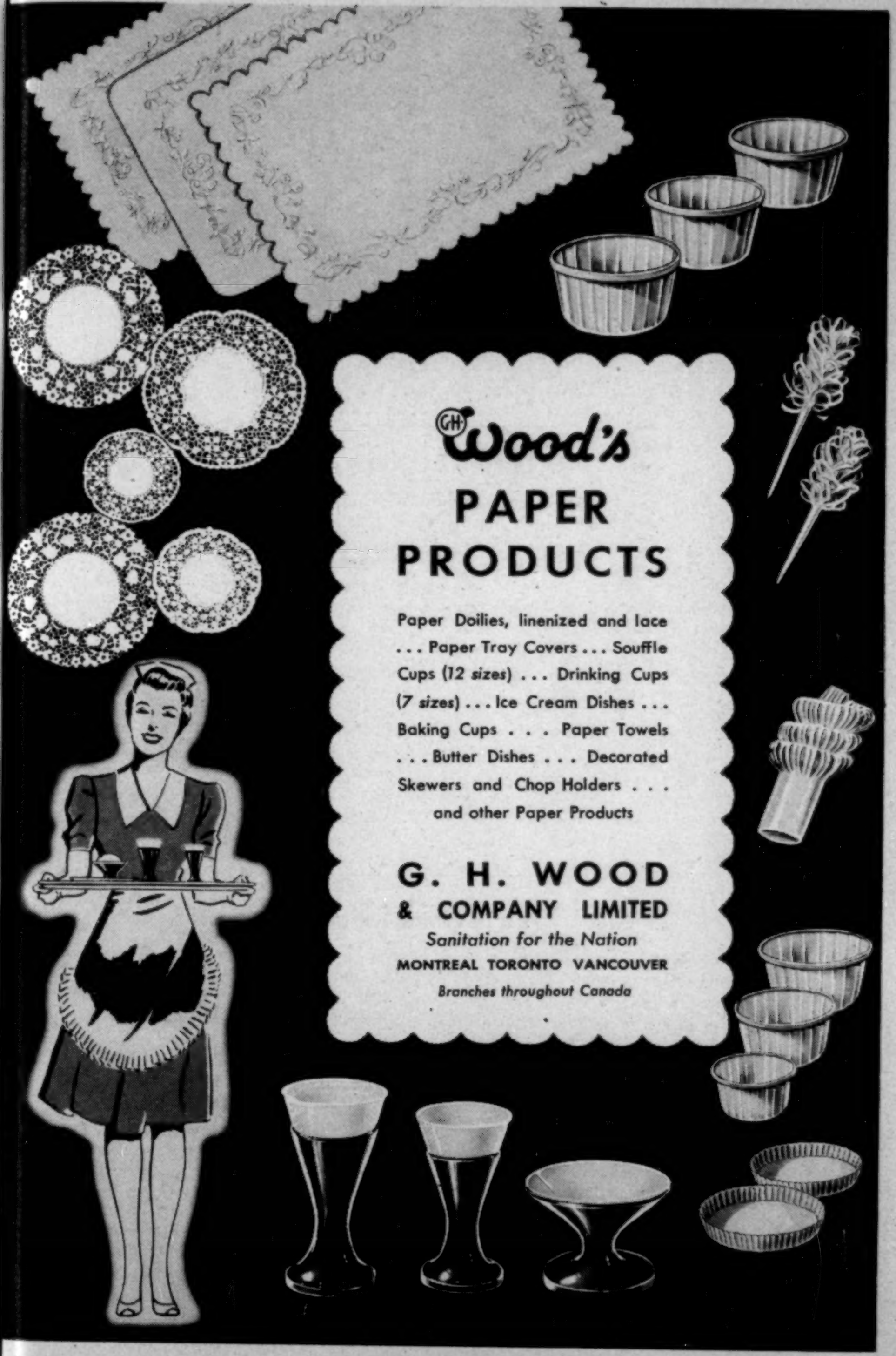
Mary L. Shepherd, who is superintendent of nurses of the Winnipeg Municipal Hospitals, has prepared a very detailed outline of the procedures that are carried out in her hospital for the admission of communicable disease patients, their routine care in "units," the technique of their discharge, etc. The program functions smoothly in the well-equipped hospital in Winnipeg which sets a workable pattern. Used in conjunction with Miss Aitkenhead's summary these techniques provide a sound basis for a modern communicable disease service.

What do student nurses do when they are off duty? **Sheila Ogilvie,** herself a fairly recent graduate from the Vancouver General Hospital, makes many constructive suggestions regarding recreational opportunities. Miss Ogilvie is engaged in public health nursing in Vancouver.

Nora Tillson had a "bee in her bonnet" about the problem of enuresis and it did not stop worrying her until she had developed the plan which she has described for us. Since this is a common problem met by nurses everywhere, we hope that many of you will put her suggestions into practice and thus bring happiness to scores of youngsters. Miss Tillson is a senior member of the City of Windsor Board of Health.

Helen E. Penhale is the very able director of the nursing education courses at the University of Alberta. She delved into some of the reasons for the shortage of nurses in Alberta and has uncovered some rather amazing information. For example, while there were a total of 1,860 nurses actively registered in the A.A.R.N., there were 2,496 inactive members. While 139 reciprocal registrants joined the A.A.R.N. from other provinces or countries, 213 migrated to other parts of the world. This shifting of nurse population is occurring everywhere and helps to complicate the supply of nurses problem.

Phyllis (**Reeve**) **Blackall** was educational director with the Metropolitan Health Committee, Vancouver, prior, to her recent marriage in England. We would all agree that the careful evaluation of a nurse's capabilities is not to be undertaken light-heartedly. Mrs. Blackall has outlined the method they devel-



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The last issue of Volume 43! As in other years, the detailed index to all of the material that has been published in this volume will be available for ready reference. Our total number of pages did not quite equal the large figure which we reached last year but then there was no special convention issue. Even if our page total is less, our subscriber total has grown considerably. At the end of 1946 we had a grand total of 8,511 paid subscribers on our lists. This year? We will not hazard a guess at what the year-end total will be. On November 1, when this copy had to go to the printers, the lists revealed that some of the provinces had taken an enormous leap since the last figures were published. Take a good look at Saskatchewan for a real thrill. In our last published report they had a total of 641. Take a look at them now! Here are the figures: Alberta, 823; British Columbia, 1,403; Manitoba, 602; New Brunswick, 585; Nova Scotia, 609; Ontario, 3,414; Prince Edward Island, 145; Quebec, 1,021; Saskatchewan, **1,203**; foreign subscribers, 616 — a grand total of 10,421.

Interest is Keen

The Canadian Nurse poster competition, which was announced in the October, 1947, issue, is arousing considerable interest in all parts of Canada. Inter-class competitions in many schools of nursing have already been reported. We have heard of one school where the director of nursing has offered a prize of two pairs of nylon stockings as the award for the best poster from her school. In another, the alumnae association is offering prizes for the student efforts. Write and tell us what special incentive your association is offering.

Remember the purpose of the competition—to provide a collection of "sales-appeal" posters for the *Journal*. Somebody in each province is going to win a fifteen dollar prize and it might just as well be you. In addition there is that further award of another fifteen dollars for the best of the nine posters.

It has been suggested that, with Easter coming early next year (Easter Sunday will be on March 28), it might be well to terminate the competition on **March 1, 1948,** so that the awards could be made in time for the recipients to do some Easter shopping. That seems a very sound idea so please note that *the closing date is advanced one month.* Send your entries in early. Be sure that they are carefully wrapped to prevent bending, crumpling of corners, etc. Send them to *The Canadian Nurse*, Suite 522, 1538 Sherbrooke St. West, Montreal 25, P.Q.

Better get busy!

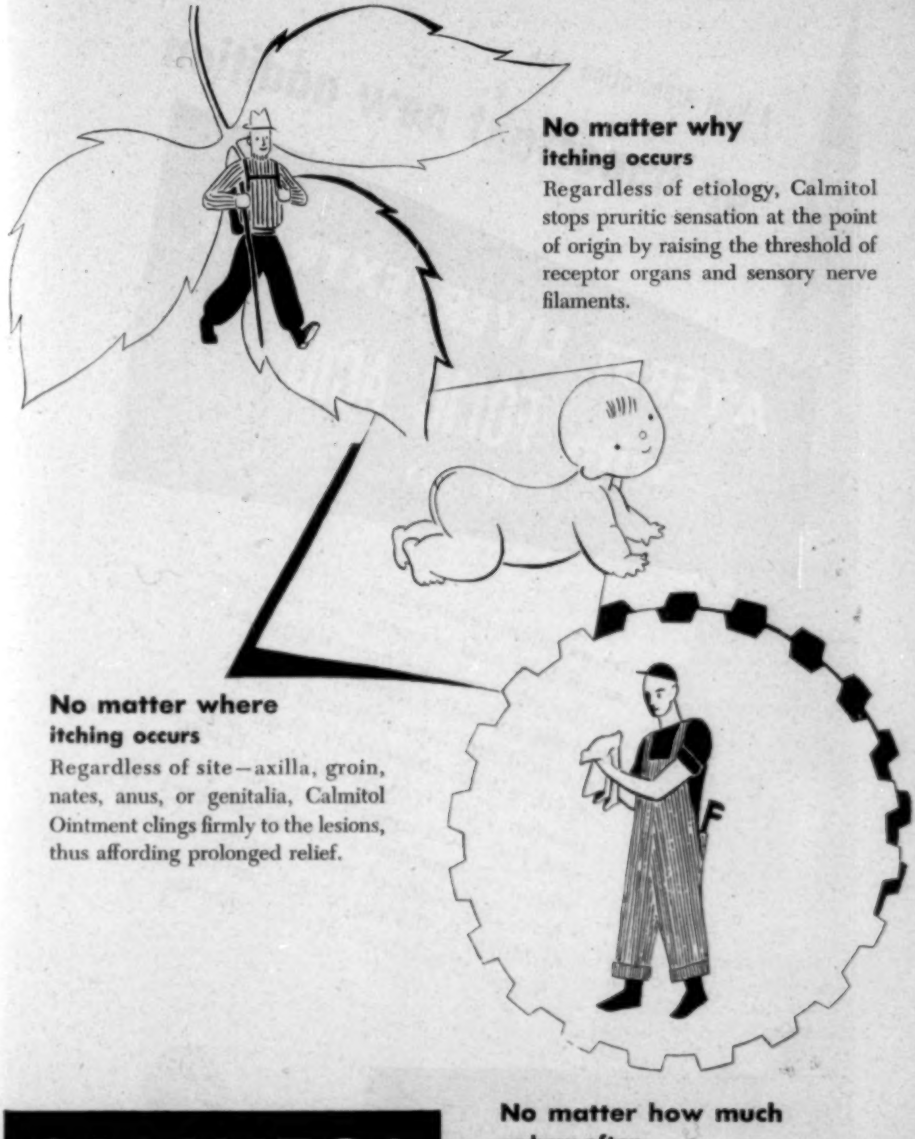
The Vermin-Killer

Many interesting and unusual ideas may be learned from the perusal of "The Vermin-Killer: Being a complete and necessary Family-Book," published in London in the 18th Century. This little book, in the collection of the History of Medicine Division, tells the reader such things as how to kill fleas, how to buy a horse, the best cure for colic, and rules to "judge the weather." The following are a few choice items:

"Recipe for the Bite of a mad Dog, taken out of Cathorp Church in Lincolnshire, in which it was solemnly recorded for the perpetual Memory of the Thing, that the whole Town almost being bitten, not one Person miscarried, but was cured, who took this Method—

"Take the Leaves of Rue pick'd from the Stalks, and bruised, six ounces; Garlick pick'd from the Stalks and bruised, Venice-Treacle or Mithridate, and Scrapings of Pewter, of each four ounces; boil all these over a slow Fire in two Quarts of Ale till one Pint is consumed; keep it in a Bottle close stopped, and give of it nine Spoonfuls warm to the Person seven Mornings successively, and six to a Dog . . . ; apply some of the Ingredients to the Part bitten. . . .

"Fox to take: Anoint the Soals of your Shoes with Swine's Fat a little broiled, and coming from the Wood, drop here and there a Piece of roasted Swine's Liver dipt in Honey, drawing after you a dead Cat, and he'll follow you, so that you may shoot him."



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REFERENCES: 1. West. J. Surg. Obst. & Gyn., 51:150, 1943. 2. Am. J. Obst. & Gyn. 46:259, 1943. 3. Clin. Med. & Surg., 46:327, 1939. 4. Am. J. Obst. & Gyn., 48:510, 1944. 5. J.A.M.A., 128:490, 1945.

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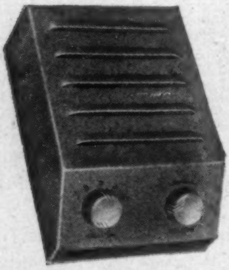

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A MONTHLY JOURNAL FOR THE NURSES OF CANADA
PUBLISHED BY THE CANADIAN NURSES ASSOCIATION

VOLUME FORTY-THREE *NUMBER TWELVE*

MONTREAL, DECEMBER, 1947

"Where We Gone"

When we hear any grossly ungrammatical phrases uttered we are inclined to be heartily amused. That was our first reaction to the supposed remark of one of those heroes of the oft-told tales. "If we hadn't came where we gone, we wouldn't have saw what we seen or did what we done." The truth behind that silly arrangement of words struck us as we began to think back over nursing progress during 1947 and we were amazed to find how much has developed.

It is customary in any up-and-coming business to do some stock-taking at the end of the year. Let us then, remember back over the past twelve months—what have we "saw," what have we "did" along the road? Where have we "came" this year? What would we have missed if we hadn't "gone" this road?

Dozens of important and interesting things have occurred. There was no national nursing convention in Canada this year but over three hundred of our colleagues attended the International Council of Nurses Congress in Atlantic City last May. This opportunity to renew acquaintances and to make new international contacts was one of the very bright spots in this year's activity.

The Canadian Nurses' Association and, through it, every member of our provincial nursing associations gained new stature this year with the federal government's seal of approval on our incorporation act. We have talked about and worked for that somewhat nebulous entity, the nursing profession, for a great many years without it having any valid legal status. Now it has. A worthy landmark this for the years to come! To Eileen Flanagan as chairman of the Committee on Legislation and to Gertrude Hall, our indefatigable general secretary, go special commendation for their untiring zeal.

A new development this year is the Demonstration School which is scheduled to open shortly. This is not planned primarily to alleviate the current shortage of nurses by producing qualified graduates more quickly. That will happen, of course, but that result is incidental to the main problem of determining just how long is required, under controlled conditions of training, to thoroughly prepare a young woman to assume her duties and responsibilities as a graduate nurse. What does it actually cost to train a nurse? No one can foresee what the results will be—*that* we will learn four years hence. In the interval, we shall watch the demonstration with interest.

One of the unsolved problems along our route this year has been the recurring difficulty of too many jobs and not enough nurses to fill them. The common cry of "Where are all the nurses" cannot be answered easily. It is an involved problem. In 1946, 3,598 students were graduated from our schools of nursing. The number estimated to have graduated this year is even higher—3,773 nurses. Where have over seven thousand nurses disappeared or have they? Hundreds of them have married and a large proportion of these are still working. Some have gone to the United States to work. Most of them are right here in Canada endeavoring to meet the ever-increasing demands for nursing service.

We could go on reviewing the myriad accomplishments of individual nurses, of the chapters, the provincial associations, but Christmas is almost here. All this month, carols will be practised in preparation for the chill hours of dawn on Christmas Day when choruses of nurses' voices will be heard through the corridors of our hospitals. The photographer caught the sparkle of happiness on the candle-lit faces of the students and graduates pictured on our cover. They are the carollers at the General and Marine Hospital, Collingwood, Ont. "Peace on earth! Good will toward men!" If only everyone meant those words as they sing them, and lived them out in their everyday contacts—what a different world it would be!

"Where have we came?" A long road—sometimes difficult, more times happy. As the year draws to a close, we, in the office of *The Canadian Nurse*, re-echo the words of Charles Dickens' character Doctor Marigold, as he said:

> My best of wishes for your merry Christmases and your happy New Years, your long lives and your true prosperities. Worth twenty pound good if they are delivered as I send them. Remember! Here's a final prescription added, "To be taken for life."

Merry Christmas and a Very Prosperous New Year!

Christmas Day in a Jap Prison

Editor's Note: This story was sent to us several months ago and we have been saving it to bring to you in this our Christmas issue. Its tale of suffering and distress, then the curious privileges which Christmas brought to these lads, imprisoned in Rangoon, presents an inspiring story. At the time it was written, one year ago, the author, who is anonymous, was completing a course in law at the University of Saskatchewan. We are grateful to him for permitting us to share this story with you.

THERE WILL BE many happy reunions this Christmas. For me it will be something more than a reunion or a holiday with those I love. It does not seem very long ago that my family were mourning my death and, unknown to them, I was mourning the fact that after four years of happy Air Force life I had fallen into the hands of the Japanese. I was shot down over an enemy aerodrome on the 11th of December and the weeks that followed are not pretty to tell about. But on the 25th, I lived a day filled with the strangest happiness I have ever known.

The story of my capture and the days that followed is much the same as those you have all read about. I was beaten, threatened, cursed and kicked till I began to wonder if it were worth the effort to try to live. The thoughts of a quick and painless death became a hope—sometimes a prayer. I was finally taken from Northern Burma to Rangoon. There I was thrown into a cell, eight feet by eight feet, and started five months of incarceration which was to be a nightmare from which I could not escape, and an education that could not be duplicated in any of our Occidental universities.

When the Allied Air Force first started to bomb the Japanese homeland, their Imperial Army broadcast to the world that they would treat any allied airmen as war criminals, if they were captured. When I was shot down I learned what this meant. At Rangoon I was thrown into solitary confinement. I was given quarter rations—that is, one-quarter the ration they gave their own troops. It was not enough to keep a man alive. That was one of their ways of showing us our mistake in being cruel, civilian-killing airmen. We, in the cells, were not allowed to talk or smoke. For those of us suffering from wounds, there was no medical treatment to ease our pain. The guards walked slowly by our cells all day long, carrying clubs the size and shape of a pickhandle. If we did not bow low to show our respect each time they passed we were given a 15-minute "lesson" with the club so we would not be so careless the next time. Life was truly hell and, since we were not able to contact the outside world, there seemed to be very little to hope for. Then, as I say, Christmas Day, 1944, arrived.

Whispered rumors that something extraordinary would happen on Christmas day had passed from cell to cell the week before, and we could only hope it would be something to make that one day a little different. Rumors were rampant—"they are going to give us an extra ration of rice . . . maybe we will get a piece of meat . . . I think we will get a cigarette." Our quarter ration consisted of a cruelly small paddle of rice per meal—no meat, no vegetables, not even a hint of something sweet, so it was not hard to hope that the Japs would realize that Christmas was "The Day" of the Christian year and would increase our rations a little. On Christmas Eve I crawled into my corner and lay on the hard boards, burning with a feeling of expectancy I had not had since I had reached maturity.

The next morning the bars of the main door were slammed back as they had been slammed back every day before. The guard marched past to check the cells. His club and the expression on his face were unchanged—both were cruel. The clacking of wooden sandals on concrete floor broadcast the arrival of the Chinese prisoners with our breakfast. I tried to stick my head through a 6-inch space between the bars, but I couldn't see them. I stood there like a little beggar child, hoping against hope that something would come to make this day just a little different. The guard walked slowly by my cell. I bowed. The Chinese were carrying their buckets of rice to my cell. The rice fell into my tin pan, a little more than usual, and I breathed a "thank you." Then the Christmas present that I will remember for the rest of my days was placed on my plate. An old Chinaman clicked up to my cell carrying a tray full of cookies, and placed one of them on my rice. A real cookie! I just stared at that small lump of sweetened rice and my heart cried thanks to the God that had made these degenerate devils do this act of kindness on this special day. As I stood silently by my door, entranced by the beauty of that little brown cookie, another Chinaman carried a pail down the corridor. He stopped and put my second present on my plate. My eyes popped. It was the foreleg of a cow! There was no meat on that huge 2½ foot of bone of course, but my bearer had served me 12-course Indian dinners in Calcutta that I did not appreciate as much. A panful of steaming rice, a cookie and a bone. Before I lifted my pan into the cell, I breathed a very sincere "thank you." We had not been forgotten.

I sat on the boards which were my bed, pressed my head against the cold concrete wall, and laughed. My pans were empty. The last sweet granule of rice was gone. The bone, so very bare of flesh when it came, was now chewed and sucked and gnawed till it was something less than a bone. I glanced at the empty pan on the floor, and my thoughts went back to dream-like days of old when, after eating an 8-course turkey dinner, I had sat back from the table and looked at the stacks of still uneaten food. The creamy mashed potatoes, the thin, delicate slices of white meat, the small round cut-glass dishes of cranberry sauce, a large bowl of spiced dressing, the many kinds of cake. I reminisced there in my cell till I felt the old glow of satisfaction steal over me. I closed my eyes and heard again the sweet and moving carols we had sung around the Christmas tree. In my imagination, I untied red ribbon and striped paper, spattered with colorful stickers from mysterious parcels. I saw my father's humorous grin as he opened yet another gaudy tie. I heard the frosty, crunching footsteps in the snow as my schoolmates arrived to see what I had received and to show me their watches and socks, books and skates. I heard my mother singing softly and humbly, "Silent Night, Holy Night, all is calm, all is bright."

"Tuskeh!" I tried to get to my feet too quickly as the Jap order for "attention" rapped through the building. An officer had returned with the guards, and my heart was palpitating madly as one of the guards walked slowly down the corridor, opening cells as he went. I stood stiffly at attention, hating the moment when the order would come to step through the door. I could only think of mass execution. Nothing to parallel this had ever happened before. The order came. I took a deep breath and stepped through the barred door. I looked down the corridor and saw fifty other bearded animals emerge and stand in wondering silence. The Jap officer swaggered to the middle of the corridor and in a stentorian voice and a school-boy accent said: "To all the prisoners in this block, today is Christian Christmas. My commanding officer has said today you will smoke. Tonight when roll-call has been taken, you will sing your Christian songs. This will be for one day only. You will not talk. The Nippon Masters are good."

His words resounded through my mind as he walked out. The guards started to distribute Burmese cheroots to every man, but we stood there as though we were struck dumb. I received five of the green-leaved cigars. I gripped them tightly and looked across the corridor at a bearded American flier standing there. He was literally a grin from ear to ear. A smoke! A real, honest-to-goodness smoke! The guard walked back and took the five of us to an empty cell at the end of the prison. He lit a match and we dragged heavily on the green tobacco. I inhaled the first drag as I used to inhale a cigarette. I thought I would never stop coughing, and the guard laughed. "You smoke Okayka?" "Hai mister—smoko goodka!" He seemed to be in a good mood and as I looked at the American I laughed like a child with a new toy. The American's countenance was composed of a magnificent black silky beard, two large coal-black eyes, and a grin that would shame a Cheshire cat. "Johnnie, can you believe it?"

We each blew a slow, lazy smoke ring and they met and folded into one another. We sat down and spent the next ten minutes grinning and blowing rings at one another. If ever a tobacco company wanted a testimonial, here was the place to get it. That ten minutes was enough to re-acquaint us with the glorious feeling of freedom that had once been a happy reality. I went back to my cell feeling indescribably happy and thankful and, as much as I hated to admit it, I felt there might be the slightest chance that a little drop of kindness might be found in a Jap's soul. I spent the rest of the day smoking those four cheroots and acquiring a murderous headache. .

The evening pan of rice was miserably small, but I didn't care. I could hardly repress my feelings as I waited for that moment when the guard would leave us alone for the night. The moment, when after days of sitting silent, of cautious whispering down the dark alley, of winks and thumbs-up signs, we would sing those wonderful Christmas carols.

The sergeant of the guard took an interminably long time checking the cells that night. He finished, walked slowly down the corridor. The bars crashed home and a moment of dead silence followed. Then a clear, deep voice sounded "Our Father Who Art in Heaven, Hallowed be Thy Name, Thy Kingdom Come. . . ." I closed my eyes tightly and leaned my head against the bars. I whispered there silently but sincerely, "Thy Will be Done on Earth as it is in Heaven." The prayer finished, a tense quiet reigned till an American drawl said, "Wal, feels if a'hm gonna get home afore my wife comes after me. We're gonna have to start this thing pretty quick—how's about singing, 'Hark the Herald Angels Sing'—eh?"

There was a Dutch boy in a cell on the top floor. He had escaped from Holland in 1940, joined the R.A.F., and had come to India to fly Liberators. He had a deep, rolling voice, still heavy with his native accent. He started to sing now. Unfaltering, deep and clear, that great bass voice rang through the ancient, darkened prison. At the very other end, on the bottom floor, another voice joined, then another, and another. Then we all joined in. The concrete walls shot our echoes back as we sang. We sang as though it might be the last time we would be able to sing. We sang and shouted those pent-up emotions into that dark and empty corridor—"Hark the Herald Angels Sing, Glory to the Newborn King." "Dutch, sing us a solo, come on, Dutch, atta-boy, Dutch." Dutch's low deep voice then reached us all. "Tonight I will sing you a song in my native tongue that I sang when I was young—it seemed beautiful then; I think it is beautiful now."

I think I shall never be thrilled by music as I was when, in those few minutes, Dutch sang, in the words of his homeland, "Silent Night, Holy Night." His voice, clear and deep as a cathedral bell, rang through the prison and out into the Burmese night. A hundred-odd miserable creatures crouched low against the barred doors of their cells and, without exception, there were soft, warm tears in a hundred-odd pairs of burning eyes. As the last echo of that beautiful melody grew fainter and fainter, I could hear the heavy breathing from cells next to mine, then a quiet voice said, "Thank you, Dutch."

We sang every song we could think of that night. We coursed through the carols and the songs we had learned at school. We listened with humorous appreciation as a Hillbilly from Arkansas sang a song of the hills and the haunts he had walked as a boy. Dutch sang "The Volga Boatman" in Russian; an English lad sang "Come, Landlord, Fill the Flowing Bowl Until it Doth Run Over" in a high, sweet tenor voice that one would expect to hear hallooing the hounds on an English hunt. When we ran out of old songs, we sang them over again and again. Hours later we lay down to sleep. Life had changed for me that night. A mass process of revisualization was going on in my mind and if ever again I walked the paths of Freedom, I would retain that sense of values. I would need so little, so very little to keep me happy.

This year I hear of shortages at home. Sugar, butter, meat—"How will we manage?" I laugh—I am going to have a happy Christmas.

New Zealand's infant mortality rate during 1946, 25.35 deaths per 1,000 live births is the lowest ever recorded by a modern country.

The Nurse in a Changing Age

ATHOL GORDON, M.D.

THE WORLD TODAY presents a fearful and wondrous picture!

Convulsed by War, Famine and Pestilence. Striving for a goal of Peace and Happiness. Hindered by diplomatic protocol, political expediency, and unworthy motivation.

There is nevertheless a motif of a different spirit to be heard above and through the cacophonous music. It is the motif of Noble Desire . . . faint and lost from time to time, but nonetheless discernible to the listening ear. Everyone who hears it longs for its continuance; and only those who can interpret it as the motif of Service have heard the true notes. I suggest to you that the great profession of nurses the world over is magnificently equipped to bring that motif to the forefront of the New World Symphony.

We are going to violate a precedent by *not* conjuring up the spirit of that great lady with the lamp, nor that of her famous literary ancestor, that equally great lady with her umbrella, and her gin bottle, Sairey Gamp. These two, though ever-present in the wings, are *not* to walk the stage of our imaginations. *Requiescant in pace.*

TAKING STOCK

The nursing profession presently finds itself in a splendidly precarious position in this changing age. I say "splendidly" for its opportunity is as never before in its history . . . and I say "precarious" for if it fails now it may go down to deserved oblivion. So perhaps it would be well to take stock of the component material, the nurse; for the profession to succeed must know itself. Burns has well said, "Oh wad some power the giftie gie us to see oursels as others see us."

The public sees you . . . and the public is a hydra-headed monster only describable in terms of very mixed metaphors. It is a wraith-like thing that no one can touch . . .a stern judge . . . a fickle friend . . . an implacable foe . . . a thing that is all soul and no soul, at once . . . a golden apple or a harp, to the politician . . . a veering weathercock to the unbiased observer . . . and, in the long run, a very long run indeed, it is an accurate assessor of worth.

What does it see as it looks at the nurse today? With the coldest impartiality it sees her as: (a) skilled and qualified . . . accepts her tacitly; (b) unskilled though qualified . . . damns her! (c) as a "practical nurse," unqualified but skilled or unskilled.

The poor man sees her: As a possible solution to his inconvenient problem of illness . . . as an added cost . . . as a much needed aid, worthy or unworthy of his financial denials . . . as an alternative to going to hospital . . . as a salvation in the internal economy of his deranged home . . . as a terrible waste of money spent on her employment.

The hospital and the matron see her: As grist for the school mill with potentialities to be discovered, and, if possible, applied . . . as a compilation of its administrative problems of housing and replacement . . . as a completely necessary component of its machine, which leaves it at the moment of achieving its maximum efficiency . . . as giving service, good or bad, from her probationer days to her graduation . . . a justification or otherwise of its power of personnel selection . . . or, as the matron would say, "Good material, run o' the mill, or hopeless."

The laboratory sees her: As a washer of test-tubes and slides . . . as a good aide, capable of routine procedures . . . as potential technician material, liable or not to depart at the call of Cupid.

The government sees her: As duly qualified under the laws of the province or the Dominion . . . as a commodity to be placed strategically in cities, towns, rural and unorganized districts in the front line of an advancing electorate. This electorate it admits should have the necessary nursing. So it sees her as a sort of chameleon, adaptable to industry, the laboratory, public health service, and capable of filling the role of medical, surgical, obstetrical, pediatric nurse at a moment's notice.

The industrialist, viewing his payments to the Workmen's Compensation Board, seeing his staff in danger (in spite of installation of safety devices) . . . viewing these things as problems or factors in his production . . . sees the nurse as a bulwark versus all the difficulties that follow in the wake of accidents, major or minor, and the subsequent complications. He perhaps does not always realize how much he needs high-grade material in the factory nurse.

The general practitioner (the obsolescent dodo of the medical profession) sees her: In the home, as a vindication of his advice that she be installed . . . or as an example of his bad judgment if she fails. In the hospital, where she is not his direct responsibility, as an aid or a horrible hindrance to the patient's recovery . . . as an aid or a hindrance to his own peace of mind about the case in hand. In the school or factory as a wise guide and counsellor, not abrogating more to herself than the situation demands . . . or as a meddlesome fool.

The patient sees her according to the nature of himself, herself, and the nature of the disease; and this view has many facets in her praise or damnation. It might be said, in general, that he sees her as a blonde . . . brunette . . . red-headed . . . mouse-colored . . . ministering angel as she sets his pulses bounding with (shall we say) sympathetic appreciation. Or as a "ditto" fiend who stands over him waving a pendant rectal catheter and prepares him for a horror before which the Johnstown flood pales into insignificance. Or as a calm quiet personality, who, when most needed, appeared . . . did things . . . brought order out of chaos . . . stepped into the family economy and restored its normal state . . . who rolled up her sleeves and did tasks quite beneath the dignity of a "trained nurse" . . . and who, from the layman's point of view, earned her pay many times over . . . but didn't get on much with that sweater she was knitting . . . and knew full well the value of few words and many deeds.

She sees herself: Ah! My friends! If I were able to speak with profound knowledge here I could do miracles. I could read the riddle of the sphinx. Even the mighty Shakespeare, who portrayed human nature more closely than anyone before or after him, was confused by the magnificent enigma of women and he fell into a morass of frustration crying:

> For men have marble, women waxen minds;
> And therefore are they formed as marble will;
> The weak impressed, th'impression of strange kinds
> Is formed in them by force, by fraud, or skill;
> Then call them not the authors of their ill
> No more than wax should be accounted evil
> Wherein is stamped the semblance of a devil.

The *idealist* sees herself fulfilling a desire for *service* . . . achieving a goal of accomplishment . . . winning prizes and praises; and succeeding in the support of herself or family . . . vindicating her existence in a society slow to value women except as an adornment to the nobility of man.

The *realist* sees herself armed for security should marriage fail to materialize, or break down after the event. (We might note in passing that the realist and the idealist may change places suddenly or gradually under the impact of circumstances.)

The *behaviorist* sees her destiny beyond the pale of nursing, and sees the possibility of contacts which will quickly lead her out from nursing into a new life, attended by a glittering host of Doctor Kildares.

The *student* sees herself in a field of specialism where she avoids the menial aspects of her profession, passionately embracing the outer garments of science or industry.

The permutations and combinations of even this small series becomes immense with the advance of age, the impact of life, and the consequent change in the sense of relative values.

Small wonder then, if, surrounded by all of life's pressures, she occasionally loses her sense of values to the bugaboo of frustration, bearing in its arms the pile of unpaid bills, and sneering at her as she faintly points to the prospective income from long overdue accounts, which she realizes are nothing but a black loss.

THE PRESENT POSITION

The history of progress is heavily lined with the story of group organization for gain: and one finds the nursing profession an organization which stands ready to carry out the prime need of today—revised, redistributed, and advanced training. Surely the present system is almost an anachronism. To expect the student nurse to jump from the classroom to ward and back again . . . to face a night of study, after a long day of mind and foot-wearing routine . . . to go from ward to examination . . . is to say the least unreasonable.

None of us feel that theory is entirely dissociable from practice; but a redistribution of study is long overdue in the training school; and the nursing profession stands for this very thing. Going to any government for financial assistance, excepting during the war years, has met with an exhalation of political "hot and cold," which is not exactly the breath of life. On analysis it turns out to be the breath of political expediency.

The thing now needed is a clear statement of the position of the nursing profession to be placed before the public in the persons of the industrialists, the public health services, the medical profession, the financiers, the farmers, the general public. The brief for each must contain arguments applicable to and comprehensible by each group approached. It should contain a request for action by such groups directed to the government. If the demand is loud enough to be *Vox Populi*, it will be construed by any government as *Vox Dei:*

Let this be so, and doubt not, but Success
Will fashion the event in better shape
Than I can lay it down in likelihood.

Much Ado IV-I:235

Among the public (and even within the ranks of the nursing profession itself) are voices which say "Why all this accent on specialized training?" What of the cost? Nurses have trained before without a special degree. Why not continue? Then out comes a whole battalion of cliches . . . "Better to learn to rub a back than to write a vitamin C essay". . . "If she can't get into a kitchen and cook what use is she" . . . and so on.

Why are these silly arguments so effective? The fault lies in the failure of those who have brought antipathy upon the whole profession. Alas, it is true that there is no task, which, well done would have brought credit, that has not been bungled at various times. . . "The evil that men (and nurses) do lives after them. The good is oft interred with their bones."

We have said nothing about the heartless exploitation of the nurse in some homes, of insults, of unkindness, of injustice. These things are written off against the kindnesses, the gifts, the friendships, the gratitude that have been the experience of most of you. Each must just keep her own mental ledger and balance it each year if possible; and, if not, she must carry forward the debit or credit balance for or against humanity. There is a value in this procedure which engenders a constructive healthy spirit of self-criticism which can only tend to good for the honest assessor.

THE ROLE OF ASSOCIATIONS

An association which merely appeals for fees is, of course an unworthy thing. One without membership fees is a ruined one. It behooves the nursing profession to gird up figurative loins, and give something very tangible to their members.

Look at the Winnipeg Medical Society which, apart from all its other activities, keeps its members briefed on the advances in all branches of medicine by the programs of its monthly meetings. Many a tip is given and taken. Many a question is subjected to all grades of critical examination, and many a man is better informed on leaving these meetings . . . better armed to carry the war against disease and death into the enemy's camp.

Nursing associations could embark upon an ambitious program of nursing education which would be most valuable. The leaders in every field of nursing could each present her special subject, giving it complete coverage and sharing her knowledge with you all. Your minds would travel from Aklavik to Atikokan . . . from the Queen Charlotte Islands to St. Pierre and Miquelon . . . from Hong Kong to Hamburg . . . from the industrial plant to the hospital . . . from the laboratory to the home . . . from the teepee of the Indian to the encumbered palaces of the rich . . . and you would gain in wisdom and sympathy, the two precious attributes of which the poor old world stands in such sore need today. Besides, it would be great fun. Rolls and coffee are not very expensive, even with the ceilings off. Attendance will grow as you feed the personnel. Those who are watching the scales can skip the bread and butter . . . but I don't imagine you will actually save much there.

All this is in preparation for the day which will surely come, when the voice of the nursing associations is more potent than that of Sinatra upon the governmental ear . . . I can almost hear them scream and swoon. Although that day is not here yet, there is no excuse for association idleness.

The laws of nature are as unchanging as the famed laws of the Medes and Persians. A leg or an arm kept long enough in a cast becomes feebler and feebler, smaller and smaller; and finally it ceases to function as a limb forever. This is the grim statement of the law of atrophy through disuse. It applies to a person, a community, or a nation with equal force. An atrophic association will reap the inevitable award of functional oblivion . . . unready to take advantage of benefits which might accrue in the evolutionary process of governmental realization.

So much for collective activity. What of the individual? Here is a rich field for further discussion. The individual member must make known her problems and her wishes. These must be given due attention . . . be given open discussion; and the questioner must be advised of the night for problem solution . . . she should come prepared to speak her piece however small . . . but she may be no speaker! In this event one must be found for her, and be briefed by her for the meeting. She must work for the association when asked . . . work hard, and work cheerfully . . . even to washing up the coffee cups.

THE EXECUTIVE COMMITTEE

And the executive, what of it? There seems to be not the slightest danger of atrophy through inactivity here, but every executive should beware of it. Its members are not *ipso facto*, superior officers, but executive servants, whose every pronouncement must be weighed in the balance of advisability and expediency, shorn of personality and tested in the crucible of experience, or the retort of experiment. . . The executive is charged with the heavy and difficult duty of satisfying disgruntled cliques, and the continual stimulation of interest. Well might it groan with Hamlet's wicked uncle: "Oh heavy burden."

The nominating committee must be widely representative and not the result of a clique selection; and its nominating slate must have a goodly list of nominees for each office. At its deliberations let it beware of the baleful effect of those railroading words: "I move the nominations closed" . . . after one nomination has been made. When electing an officer let each member review the candidate under the headings of *experience* . . . *personality* . . . *enthusiasm* . . . *ability* . . . rejecting her if all these are not found. These attributes are hard, indeed, to find in one and the same person; but they are absolute prerequisites in an elected executive officer. Personal feelings are bound to be present but they must be sternly repressed by each of you as you prepare to ballot . . . for are you not ballotting for the successful operation of your association?

The fact of evolution in the great scheme of things is too well established to be gainsaid; and the principle of adaptation to environment is amply demonstrated. When through millions of years the fish slowly took to the land to become a lizard it only very slowly shed its gills, took its lungs within its body case, and developed the typical pentadactyl limbs; but it never went backward.

Nursing associations might well follow, to some extent at least, this evolutionary form of development. It is better far than the revolutionary form, and a failure to make a sharp and immediate advance should not be viewed with antipathy borne of frustration, but rather as an indication that its own internal development had not completed its adaptation. The subsequent evolutionary stage will follow as the night, the day. Nothing will stop it.

In spite of the trend toward specialization, there are always to be found certain nurses who are intrigued by the idea of taking care of someone. Their whole aim is the doing of this grand job . . . call the instinct what you will—maternal instinct, sublimation of a frustration, a complex of some kind or other . . . but when one of these is given a good brain, a deft pair of hands, a good physique (especially arches and back) there appears a creature beloved of suffering people, and a veritable gift to the world, one for whom there might well have been another beatitude: "Blessed is the nurse, for she shall be called God's shield against pain."

They tell us that Canada stands on the verge of a great future. So indeed she does. That future depends on many factors ponderable and imponderable.

Canada maple land: Land of great mountains
Lake land and river land: land twixt the seas.

And we may well pray:

Grant us Lord, hearts that are large as our heritage
Spirits as free as the breeze.

But while a nation grows today, it does so under the terrible shadow of the four sinister horsemen of the Apocalypse—War . . . Famine . . . Pestilence . . . and Death. Arrayed against this awful force stands medicine and its glittering handmaiden, science. Their shields gleam with the polish of achievement and are sadly dented with the grim marks of failure; but their bearers stand undaunted and unafraid.

But who is this who, standing beside them, wields the weapons they have forged, and casts a protecting arm around the wounded and sick? It is the nurse . . . the plain girl . . . not always with scholarships, but with good training, indomitable courage, and an unquenchable desire to serve. She must be the child of St. George and St. Joan, this nurse of the future . . . this child of God.

Leukemia

Leukemia is considered to be a malignant disease, and as such its death rate may properly be included with that from cancer. For the period 1941-45, the death rate from leukemia was about 4 per cent of that from cancer. Furthermore, among white males, the mortality from leukemia is higher than that for cancer of any site except the digestive tract, the prostate, and the lungs; in early childhood, it exceeds the death rate from all forms of cancer combined.

The death rate from leukemia is higher among males than among females at every age period; the widest difference is in late childhood and adolescence, when the rate for males is about twice that for females. Persons afflicted with the disease, irrespective of sex or age, live only a relatively short time; to date, recovery has not been reported in any authenticated case. However, the newer methods of treatment, now being tried, give some promise.

— *M.L.I.C. Statistical Bulletin*

More than four hundred Canadian Army officers and men were killed or wounded during air attacks on Great Britain in World War II, the army's historical section has reported.

Communicable Disease Techniques

MARY L. SHEPHERD

THE Winnipeg Municipal Hospitals are responsible for the care of all cases of acute communicable disease requiring hospitalization. This care is provided by student nurses affiliated from the general hospitals of the city, working under the supervision of a graduate staff. Definite techniques or procedures are required to provide uniformity of care, to prevent cross-infection, to safeguard indefinite cases, to protect those working around the patient, and to avoid the spread of disease to well persons in the community.

The actual accommodation provided for patient care must be so planned as to ensure *plenty of space* so that nurses may enter the ward in safety without contaminating their uniforms while putting on the gown. Space is required also so that separate technique may be carried out for each patient in a given area.

THE NECESSARY SET-UP

In our set-up, we limit the various communicable diseases to a given unit, each complete in itself. Our practice is to divide each room into *separate units*, with each unit numbered for convenience. The unit consists of a bed, bedside table, chair, and the surrounding wall. Everything contained within that unit must be washable and soap and water are used freely to keep it clean. We provide each patient with towels, face cloth, soap, soap dish, comb, and tooth-brush. These articles are kept within the immediate area of the patient. All other articles are removed. Basins, bed-pans, etc., are boiled for ten minutes after each use. Papers, letters, and books are burned. After the attendant has handled anything which is contaminated, she must wash her hands and arms thoroughly with soap and running water for two minutes before going to other units or to clean areas.

Gown technique is very important. The nurse's gown must cover her entire uniform. Our gowns are made with elbow-length sleeves, ties at the neck, open all the way down the back, with ties that fasten around the waist. There are lockers or stands on which to hang the gowns. These are numbered to correspond with the patients' units. They are placed on the opposite side of the room from the beds so that the patients cannot reach them. The actual technique we follow is explained in detail below. An ample supply of doctors' and nurses' gowns should always be available.

Sinks with *running water*, preferably those operated by foot pedals, should be conveniently located. We have sand-glasses at each sink to "time" the scrub.

Sterilizers form an important part of the equipment of a communicable diseases hospital. We have large, deep, monometal sterilizers with steam attachments in each kitchen, in which we boil the dishes and trays. Similar sterilizers are in each service room for boiling the basins, etc. Bed-pan sterilizers are installed also.

The hopper into which bed-pans are emptied is always considered contaminated and thus a source of infection. The nurse must, therefore, scrub after emptying the pan and before returning to any patient's unit. The soiled linen chute is also considered contaminated and the same technique is used as following the emptying of a bed-pan.

All floors are considered contaminated.

CLEAN AREA

Certain areas are kept "clean" or uncontaminated at all times. These areas include: (a) the nurse's desk; (b) all linen and supply cupboards; (c) all medicine cupboards; (d) the entire service room excepting the linen chute, hopper, and floor; (e) the entire kitchen, with the exception of the floor; (f) all units not occupied by patients. These have been thoroughly cleaned following the discharge from hospital of the last occupant. If any clean unit should accidentally become contaminated, it is immediately washed with soap and water.

All windows, window-sills, screens, and sinks are kept as clean as possible. The wards are aired thoroughly at all times.

AMBULANCE TECHNIQUE

The entire ambulance is clean and uncontaminated when it leaves the hospital to pick up a patient. The driver dons a white coat before he enters the home. If the patient is ambulatory, he may walk to the ambulance. However, if a child is carried out from the home, he is wrapped in an ambulance blanket or placed on a stretcher. The patient is taken to the admitting-room where a nurse receives him.

The ambulance driver immediately removes the white coat and places it in the proper receptacle, together with the contaminated blankets, pillow-cases, etc., used for that case. The entire interior of the ambulance is washed with soap and water, then aired. Fresh blankets and linens are put on the stretcher to be in readiness for the next call.

ADMITTING-ROOM TECHNIQUE

Excepting for the floor, the entire admitting-room is considered "clean" when the patient enters. The desk is always kept clean. In it will be found: the admitting book; cards and information forms; valuables envelopes; clothes lists, to be completed in triplicate; culture tubes; tongue depressors; antitoxins; sterile syringes. Completely equipped trays for giving antitoxin or a lumbar puncture are at hand.

Care is taken to prevent the patient or any visitors from touching the desk or anything on it. The chairs for parents or others who may have accompanied the patient are so placed as to be away from the desk and also from the stretcher on which the patient is lying.

The stretcher is covered with a large sheet, adjusted so that it overhangs both sides of the stretcher. These ends will be used to cover the patient when he is being wheeled to the ward. A large blue light is placed directly over the stretcher to permit the examining doctor to see the throat, rash, etc., without difficulty.

In a clean cupboard there is a supply of gowns for the protection of the doctor and nurse. Nearby is a container for contaminated gowns.

Procedure: With the patient on the stretcher, the relatives on the specially-placed chairs, the doctor proceeds to take the history before he becomes contaminated. The nurse prepares the clothes tags, valuables envelopes, etc. She has a hospital night-gown and sponge blanket in readiness before she dons her gown. Since the personal clothes of patients are never taken to the ward, the nurse undresses him, places the clothes on hangers and tags them. A contaminated clothes room is nearby. The clothing remains there until removed by an attendant. The room where they have been hung is sprayed with Izol solution.

The valuables are checked with the patient, then placed in an open valuables bag, the outside of which is not contaminated. Money and papers will later be autoclaved. Other valuables, such as jewelry, which cannot be autoclaved safely, are washed with soap and water and placed in a clean bag. All valuables bags are labelled and locked up in the business office.

Meanwhile, the doctor, having completed the history, puts on a gown and, with the assistance of the nurse, takes the throat culture and makes a complete examination of the patient. It is essential that a correct diagnosis be made here, if possible, so that the patient may be taken to the proper ward. Indefinite, atypical cases are always kept in separate rooms, away from all other patients, until the diagnosis is ascertained. This completed, the doctor removes the gown, scrubs for two minutes, then enters the signs, symptoms, and diagnosis on the history.

As soon as the relatives leave, the nurse washes the chairs thoroughly with soap and water. No other part of the admitting-room has been contaminated. She then removes her gown, scrubs for two minutes, and folds the over-hanging portion of the stretcher sheet over the patient. She handles only the outside, the clean area of the sheet, and so avoids any danger of contamination between the admitting-room and the patient's unit. If by any mischance the stretcher should become contaminated during this process, it is washed immediately with soap and water. A clean sheet is placed on it in readiness for the next patient.

GOWN TECHNIQUE

Gowns are worn for all bedside care. The gown is hung up with the *clean* side inside with the opening facing the nurse. It is hung out of the reach of the patient.

The following procedure is used in putting on the gown:

Reach through the opening at the back of gown to clean area inside, and lift gown from hook. Slip gown on, handling only the inside, still keeping hands clean until strings at back of neck are tied.

Grasp the two edges of the gown at back, fold together, and overlap slightly to hold gown together. Then, with hands now contaminated, cross ties at back of waist, and tie securely in front. Wear until entire unit care is completed.

To remove the gown, these steps are just reversed, as follows:

Undo ties at waist, and let them drop. With hands still contaminated, lift one corner of gown (about area of right hip) from outside and tuck under opposite arm. This is to keep the gown from falling forward, as the nurse bends over the sink to scrub, thus contaminating sink.

Turn contaminated sand-glass and scrub hands and arms with soap and running water for two minutes, using brush on nails only.

Dry hands and arms thoroughly with small towels provided (kept in basket above sink) and discard towel into basket below sink. With clean hand, reach under to the clean area of gown being held under left arm, and let the gown down. Unfasten ties at neck of gown. Then, handling inside of sleeves, bring them down over hands.

With both hands still inside armholes of gown, place the two clean sides of the gown flat together, secure the open areas at back of gown securely together, then, catching both armholes (and with hands now contaminated from outside of gown) hang on hook.

Take basins, linen, etc., from unit to be sterilized. Scrub hands and arms for two minutes.

Care must always be taken to avoid contaminating face, hair, or uniform. Gowns are changed frequently. We do not use caps or masks in the care of these diseases. Hair is worn securely pinned or in hair-nets.

THE PATIENTS' TRAYS

The meals are served to patients on individual trays from the steam-table which is brought to the ward. Second servings may be had if desired and then the food remaining is returned to the main kitchen at once. Before any contaminated trays are brought back to the ward kitchen, the table is covered with newspapers to keep it clean. The tap is turned on and left running to (a) rinse all dishes before boiling them and (b) to avoid contaminating the taps.

As the contaminated trays are brought out, they are placed on the newspaper, the trays stripped, the dishes rinsed, then piled with the trays in the sterilizer. The newspapers are folded up and placed in the waste can.

After the hands have been scrubbed up, the sterilizer is filled with water above the level of the trays and dishes. The steam is turned on, and when the water begins boiling it is left to boil for ten minutes. The dishes are removed from the sterilizer, washed with soap and water, and reset on the trays.

PREVENTING SPREAD OF INFECTION

As important as the nursing care given to the patients is the protection of the nurse herself. Every effort is made through careful observance of technique to prevent those giving care from becoming infected. Additional practices include: recent immunizations; maintaining good physical well-being through adequate diet, fresh air, and sunshine; early recognition and isolation of the ill person, etc. The nurse is warned not to take any chances with the technique even though she may have had the disease already. She *might* develop it again and she would certainly be a hazard to those who were scrupulously carrying out every detail of the technique.

The patients are instructed to remain in their own units. This is especially difficult with small children who are tempted to hop out of bed to rescue their playthings from the floor. Patients are always reminded to cover the mouth when coughing or sneezing.

Concurrent disinfection means that the patient's unit is kept as clean as possible. In addition to the daily bath and frequent changes of linen, regular dusting and cleaning are provided. A damp cloth is used for dusting. Dustbane keeps the dust down in sweeping. The nurse should avoid creating dust by shaking the sheets and blankets. All articles taken from the unit are sterilized or washed at once. Papers, letters, scraps, etc., are removed and destroyed.

Terminal disinfection is begun as soon as a patient is discharged. All papers, books, toys, etc., are burned. The linens and blankets are sent to the laundry where the following procedures are routinely carried out:

1. Sterilization of all *white linens* in a 1% liquid bleach. This is in the proportion of 2 quarts of bleach to 100 pounds of dry linen. The first wash is in water at 170° F. for 10 minutes followed by the second at the same temperature for 20 minutes.
2. Underwear and other washable articles — Steri-chlor is used. (It is made from lime powder but with the bleaching agent removed.) Here 8 ounces of Steri-chlor is used to 50 pounds of dry clothes.
3. Clothing infested with pediculi is autoclaved in dry heat for 30 minutes.
4. Pillows and mattresses are autoclaved or sprayed with Izol solution and aired.

We use a variety of solutions to suit specific situations. Instruments are boiled or soaked in Lysol solution. Combs are placed in Zephiran solution. Jewelry is sponged with alcohol. Wash basins, gargle cups, kidney basins, soap dishes, etc., are boiled for ten minutes. Bed, table, chair, and wall are washed thoroughly with soap and water and aired, immediately after the mattress and pillows are removed.

To Discharge a Patient

Prior to discharging a patient, the bathroom is thoroughly washed. The clean clothing is taken in and deposited in the uncontaminated area. Towels and a bath mat are placed there also.

A board is placed across the tub on which are basins and a pitcher of water for a shampoo. The nurse washes the hair very thoroughly, then ties a towel around the patient's head. The patient remains at the end of the bathroom away from where his clean clothes, etc., have been deposited until the nurse has removed the basins, pitcher, and board. In the case of children, the nurse remains during the discharge bath. Otherwise, she gives instructions for the disposal of the contaminated clothes, prepares the bath, and indicates the clean attire. When he is dressed, the patient is guided to a clean room where he will be called for.

The bathroom is washed throughout with soap and water and left clean.

Editor's Note: Next month we will conclude Miss Shepherd's detailed outline of communicable disease care with instructions on how to look after a case at home and a summary of the main points in the nursing care of the various common communicable diseases.

Of the 162 Canadian veterans blinded in World War II, 55 were prisoners of war following their capture at Hong Kong. The condition of the latter was largely the result of nutritional deficiencies while in captivity. Of the total of war blinded, 60 are reported as satisfactorily employed.

— *Veterans Affairs*

Recreation for Student Nurses

Sheila M. Ogilvie

Did you ever feel disgusted during training? If so, did you ever enquire the reasons for this feeling? You will probably have found that it derived from two separate sources: (a) a constant series of rebuffs or an especially strenuous period of work; (b) a sense of a lack of adequate recreation.

Ignoring the first, I shall try to point out three aspects of recreation—physical, cultural, and social — which I am sure can enrich student life.

Let us first think of physical recreation. We are only too well aware, all of us, that many student nurses flatten their feet from excessive walking and all develop a certain amount of muscle tone in their arms from lifting patients and mattresses. This is all exercise, of course, and we often felt quite worn out after it. The fact remains, however, that it is not balanced exercise and it is not carried on out-of-doors. There is so much walking involved in confined atmospheres that at the end of the day the tendency is just to flop down. This is unfortunate and not conducive to the best health, for it is important, nay, I would even venture to say imperative, when one is all the time attending sick people, to get out-of-doors and engage in some form of physical activity. If there is no provision made for the students' physical recreation, there is often no alternative but more walking. Now walking is an excellent activity and one which should be indulged in more frequently, but for student nurses, who do nothing else all day, it has only a limited appeal.

There are many excellent sports which produce great enjoyment and physical development concurrently. During the milder seasons of the year many enjoy tennis and there should be a suitable number of courts in connection with the school for that purpose. Organized games and tournaments can be instituted which would encourage team-work and good fellowship. Some form of playing-field is very desirable, where baseball, hockey, and any other athletics which the girls want can be conducted.

Indoor athletics are vital during the winter months. A fully-equipped gymnasium should, therefore, be a part of every school, where badminton, basketball, apparatus-work, etc., can take place. Expert instruction might even be introduced at regular intervals when the majority of the students could take advantage of it. If opportunities for swimming, hiking, riding, skating, and skiing in the vicinity are available, the students should be encouraged to participate in these, and special facilities, such as transportation could be provided for their convenience. In a word, nothing is so important as the maintenance of health and, once an excellent physical recreation program is established, the student will be able to study and nurse with greater zeal.

The next type of recreation to be considered is cultural, and the avenue to that is good books, good music, and good entertainment. A fine recreation library in charge of a trained librarian should be at hand in the residence for the use of all students. A large and divers collection of books of a high standard is advisable, with attention to the classics, autobiography, travel, and modern thought. In addition, a periodical section is advantageous, where non-nursing magazines and weeklies of a reasonably high standard are a *sine qua non*. For many students, this library will afford an opportunity to develop a sound appreciation of good literature and keep them in touch with the larger affairs of the world without.

Music, too, is so much desired by many people that it is a shame if no facilities to play and listen to music are present in the student's life. Girls who sing or play instruments want to continue doing so even though they are learning to be nurses. To that end, a specially constructed sound-proof music-room should be available for all, where there is privacy for them to practise alone or in groups. A library of recordings to suit different tastes, stored in an adjoining room, suggests itself at once as a useful corollary.

As for general entertainment, the above-mentioned orchestral groups and scheduled programs of recordings from outside sources could provide much pleasure in the evenings and thus help to brighten the lives of the student body as a whole. Need I add, in the same connection, plays, movies, and speakers prominent in their own field? Where the girls are cut off from outside interests, training can become a very stifling process; so much so indeed that after a while they find it difficult to converse intelligently on varied subjects. Any steps taken to avoid such a condition is more than worthwhile.

My third section, social recreation, provides for adequate mingling of students with other young adults who are not connected with nursing. It would be stimulating in the highest degree for them to feel that they have every opportunity to meet their friends and entertain them on their own premises in gracious surroundings. A home-like atmosphere means so much, especially to students who are so often far removed from their own homes and who must, therefore, rely solely on the hospital for the greater part of their social life. Dances held frequently are a great boost to morale and, in addition, parties among the students themselves and also shared with other groups in the community are valuable. Special events, such as a Christmas party, can be made into extremely happy occasions too.

Perhaps I may be regarded as asking too much when I mention all these encouragements for students and yet I do not think so. We ourselves have seen in our visits to institutions for delinquent girls that intellectual and physical recreation is far from being neglected. Why then should not similar or even greater facilities be forthcoming for young women who are devoting themselves to such a worthwhile cause as nursing? It must never be forgotten that girls in training are young and active and, as such, desirous of living their lives to the fullest possible extent. It is all the more important that they be encouraged to do so because training, of necessity, involves a certain exclusion from ordinary outside activities. Therefore let us develop physical, cultural, and social recreation for student nurses and make them healthier and happier girls.

Vitamin C in Potatoes

Do you know that one average-size potato, properly cooked, contains enough vitamin C to supply one-third of your daily requirement of that vitamin which is essential to your health? By properly cooked we mean potatoes should be baked, steamed, or boiled in a covered pot with their jackets on.

Vitamin C can be destroyed by over-cooking, especially in rapidly boiling water in an open kettle. Those who eat boiled, pared potatoes are deriving great benefit from the energy-giving value of the potato, but are losing the vitamin values which could be so easily retained.

Vitamin C is given credit by present-day nutritionists with being one of the most important inhibiting factors in preventing the occurrence of certain symptoms such as tender joints, headaches, low resistance to infection, digestive and nervous disturbances, general weakness and restlessness.

Valuable for teeth: Ascorbic acid, which is found in vitamin C, is necessary for norma. activity of certain cells which are responsible for laying down the calcified structures in teeth. A mild deficiency of vitamin C results in defective teeth and bone formation.

Baked potatoes, eaten along with the skins, are the most nutritious. By eating the skins you will get the benefit of all the minerals which lie close to it.

Steamed potatoes are preferable to boiled because the elusive vitamin C, though easily destroyed when potatoes are cooked in water, is not as quickly lost when cooked in steam.

If you must boil your potatoes, do so with the skins on.

—*Health News*

Summary of the Working Party Report

WITHIN the past few months newspapers and journals have carried excerpts from and comments upon the *Report of the Working Party on the Recruitment and Training of Nurses.* This committee was set up in January, 1946, in Britain, by the Ministry of Health, the Department of Health for Scotland, and the Ministry of Labor and National Service. Its directive was to "survey the whole field of the recruitment and training of nurses of all types." In commencing the study, the Working Party realized that their objective "should not be to attempt to formulate interim proposals to remedy or palliate the difficulties of the present . . . but rather to assess, if possible, what nursing force, in terms of quantity and quality, is likely to be required in the future . . . and to suggest how best that force can be recruited, trained and deployed."

They were aware that numerous studies of nursing conditions had been made which had borne fruit to a limited degree but "a new departure in method seemed to be called for . . . to arrive at some degree of finality in considering these problems." This report indicates the wisdom of their decision.

The study found that "to some extent the long-term solution of the problem of staffing the nursing services lies in reducing the burden of sickness." "Clearly the problem of sickness can be attacked quite as much by reducing the number of patients as by increasing the number of nurses . . . The proper stage for the estimation of *sick nursing* requirements should be subsequent to the optimal requirements of *health nursing* services." The rapid development of preventive services in the past quarter century and the accompanying reduction in the total amount of illness is abundant witness to the wisdom of this thesis. (In Canada in 1944, total maintenance expenditures for general public hospitals in the care of patients was $69,053,000 compared to the relatively small sum of $6,456,000 spent on the general public health developments.)

The Working Party found, in studying the present conditions existing in nursing, that "nearly half the total number of nurses in hospitals, including students, have received full-time education up to the age of 14 or 15 only. Another 30 per cent have received some further education . . . without reaching school certificate standard. One in every six has reached . . . matriculation standard but has not proceeded further. Some 4 per cent have been educated to higher certificate standard . . . 1 in 200 has a professional diploma or a university degree."

It was found that some 55 per cent of the nurses transferred to nursing from some other employment, the inference being that these filled the gap between leaving school and starting to train with available work. The report suggests that "pre-nursing courses . . . for girls between 15 and 17 or 18 would make a valuable contribution to nursing recruitment." Regarding the desirable age for girls to enter schools of nursing they state " . . . it would seem that candidates should be accepted at the age of 18 years, though not younger, perhaps, but every encouragement should also be given to candidates of more mature years." They were definite in their stand that married women should have an equal opportunity both to enter the field of nursing and to win promotion following graduation.

Discussing the alarming problem of student nurse wastage, the report states "wastage . . occurs not simply from demanding too much of the duller student, who gives up the unequal struggle when confronted with too difficult a task; it arises also from lack of appreciation of the gifts of the brighter student." A very detailed investigation was made into this problem since there was an average loss of 36 per cent from each annual intake of students over a 7-year period. Some of the findings included in the report are:

> While some part of this wastage is undoubtedly due to the admission of candidates who lack the ability or the temperament to pursue the training successfully, the exceptionally high rate of wastage among student nurses very definitely suggests that they are expected to work and train under conditions which even many of those suitably equipped are not prepared to tolerate.
>
> Generally speaking, there is a considerable sense of frustration and discipline is felt to be harsh and cramping and quite out of accord with modern notions of personal freedom . . . not referring so much to disciplinary requirements in periods of duty, but more to the restraints imposed upon a nurse's freedom in her personal life when she is not on duty.
>
> . . . senior members of staff are not really aware of, or fail fully to appreciate, the outlook of the younger generation. . . . the difference in attitude between a nurse who gives up training and one who does not is a difference in degree not in kind. . . . they would leave not because they dislike nursing but because the conditions of training are to them all but intolerable. Those who leave do so . . . because they have reached breaking-point.

After reviewing the major reasons for wastage which centred around problems of hospital discipline, the attitude of senior staff, food, hours, pressure of work, the Working Party concluded that "nurses in training must no longer be regarded as junior employees subject to an outworn system of discipline. They must be accorded full student status so far as the intrinsic requirements of nurse training permit."

> Experience teaches that . . . it is of little use merely *appealing* to hospital authorities to modify discipline or to adopt more understanding attitudes. The introduction of *structural* changes in the organization and staffing of training schools is certainly needed.

Emphasis is placed on the fact that the present basic training places greatest stress on preparation for institutional sick nursing, instead of giving all nurses an understanding of their potential usefulness as health teachers. Moreover, endless hours are spent on "non-nursing duties which could be properly performed without any nurse training at all." From the data available, the Working Party estimated that the percentage distribution of training hours spent in nursing and domestic duties was: First year, 67% to 33%; second year, 76% to 24%; third year, 84% to 16%.

> It would thus appear possible, by reorganizing the system of training and treating student nurses as students, to provide within a period of two years a training at once more comprehensive and more effective than that now given. In our view this wider training is essential if the preventive and curative aspects of nursing are to be properly integrated.

Their proposals for the new type of training would necessitate a complete revamping of the existing arrangements. Instead of the present three-year general training followed by an additional year for obstetrics or pediatrics, etc., the Working Party report recommends that:

> . . . a course of training lasting two years might be devised for all nursing fields, of which the first eighteen months would be devoted to a common content for all students, and the remaining six months be concentrated study and training in a chosen field. In this last six months a student might elect either to continue with general medical and surgical nursing or concentrate on public health, psychiatric, or pediatric nursing, or on communicable diseases, including tuberculosis . . . at the end of which, (the two-year period), and subject to examinations, nurses would be granted provisional State registration and would be entitled to the pay, status, and title of State Registered Nurses. They would then be required to spend a third year in nursing practice under supervision before provisional registration would be confirmed.
>
> One special feature of this scheme is that . . . it would provide a basic training for public health nurses. In the past, training for the public health field has been superimposed at

the "post-graduate" level on hospital training. It appears doubtful whether a nurse, who has been in constant contact with sick people for three or four years, can so readjust herself during subsequent training so as to be able to assimilate the essential principles of social and preventive medicine.

We suggest that the State examination in the new scheme might be divided, as now, into two parts — the first taking place at the end of eighteen months and the second at the end of two years. The first examination would embrace the whole content of the common course; the final examination would be closely related to the specific content of the chosen period. . . . the student would qualify as a State Registered Nurse. . . . she would not, however, be permitted to engage in private practice, or be employed otherwise than under supervision, until she had completed a further year's work under an appropriate supervisor.

No training scheme is planned to produce a completely "finished" product with nothing left to learn. . . . too much should not be crowded into the actual training period. . . . we must distinguish between what belongs to training proper and post-training respectively.

. . . under our scheme the period of four weeks' maternity nursing included in the first eighteen months of training might be followed, in the optional period, by six months' intensive study in midwifery. Our enquiries . . . suggest to us that it would be wholly desirable that nurses and midwives should have a common basic training, thus leading to unification of the nursing profession.

The Working Party recognized clearly that if the students are to come to their true status, definite conditions must be met. They must not be hampered "by the staffing requirements" of the hospital. "Adequate and stable domestic and nursing staffs" are imperative. ". . . the rotation through hospital wards and departments must be dictated by the nurse's needs as a student . . ." The immediate necessity for financial assistance for such a development becomes apparent at once. The report is definite on this matter:

The cost of training should be dealt with entirely separately from the general maintenance expenditure of the hospitals in which training is given. Without question the present financial dependence of nursing schools upon the finances of the hospitals to which they are attached nullifies any serious attempt to improve the training of nurses. Student nurses would cease to be employees of the hospital and would not be bound by contract to an employing authority.

Money is available from the public treasury for other forms of education. At last it is proposed that nurses' training be given the same form of financial backing.

Very positive recommendations were made regarding the working hours of students:

. . . the training day must be reduced in span so that it approximates as closely as is practicable to that of the normal working day and this involves the introduction of a three-shift system. . . . we have discussed the question with large numbers of nurses of all grades and, generally speaking, they declare their wholehearted preference for a shift system. We have not met any evidence that the shift system is not popular with patients or is bad for them. As far as student nurses are concerned, the day is now broken up into periods on the wards, in lecture rooms, or off duty, and is more fragmented than it would be in a shift system which would make it easier to systematize training. Among its many advantages may be counted the opportunities of non-residence, of having free time at the same hours as persons in other occupations, and avoidance of the insular and cloistered life of an institution. . . . so far as student nurses are concerned, we consider that the span of daily duties should not begin before 8 a.m.

The present plan of recompensing students for services rendered would necessarily be altered. The Working Party suggested that:

Students should receive, in addition to board residence (or allowance in lieu) and free tuition, a grant to cover personal expenses to be paid by the training authority.

A variation on one form of the central school plan which is being studied in Canada is proposed as the most feasible means of bringing these proposals into fruition:

> Hospitals and public health agencies will together form a composite training unit covering the whole nursing field. Students would be students of the unit passing from one institution to another as necessary in the course of their training.
>
> Teaching resources of the several institutions forming a training unit would be a common pool and full-time teachers made mobile so far as necessary to ensure the best qualified instruction in the various subjects of the curriculum. . . . to ensure continuity of teaching and supervision, it will be essential for ward and departmental sisters to retain a distinct teaching function. . . . the content of nurse training should be strictly determined by one central criterion, namely, the extent to which *items of training contribute to reduce the incidence or duration of sickness.*

Before terminating their report, the Working Party considered the matter of the over-all organization which would have jurisdiction over the examinations, registration, etc., as well as providing for continued research in nursing.

> . . . there should be set up one governing body covering all fields of nursing in England, Wales, and Scotland. This General Nursing Council for Great Britain should include, in addition to government representation and nurses elected on a regional basis, a due proportion of university and other educational representatives.

How would these proposed changes affect the status of the assistant nurse group who today are required to take a two-year training? Would a total of more graduate nurses result from the more careful selection of candidates for training and the revamped form of education? The Working Party concluded their report with statements covering these points, as follows:

> For some time it will be essential to use the services at least of those assistant nurses now employed, but such a grade with a two-year training should not be perpetuated. The roll should be closed at a given date and to fill the gaps their duties should be allocated partly to trained staff and partly to nursing orderlies who would replace assistant nurses.
>
> The additional staff required to give effect to student status and the three-shift system cannot be less than 22,000 to 24,000 trained nurses and some 14,000 nursing orderlies. This would raise the trained nursing force from 88,000 in December, 1945 to 112,000. . . . the requirements could theoretically be met in five years by reduction of wastage, but this takes no account of increase of staff to allow for expansion. All restrictions on the employment of married persons in the nursing services must be removed, part-time service developed, and the use of male nurses extended. . . . to provide for existing needs and training reforms would seem to require a trained nursing force of not less than, say, 120,000 to 125,000.

The report fails to indicate just where the desirable candidates for the schools of nursing are to come from or how the personnel to perform the domestic duties are to be retained within the hospitals. The full report merits careful study by Canadian nurses. Our schools of nursing have been faced with many of the problems which beset those in Britain. Student wastage, too many non-nursing duties, etc., we have them here! Suggestions have been made that our methods of training are antiquated and need to be remodelled. Full understanding of the implications of this report will strengthen Canadian nursing leaders as they seek for a solution to our problems.

Food Models to Color

Four sheets of outline drawings of foods, closely approximating actual size, have been produced by the Nutritional Division for practical study of individual foods and menu-planning. The sets contain suggestions for breakfast, lunch, dinner, and extras. The foods are outlined in black and white on manila paper and are to be colored, cut out, and mounted. For classroom use a suggestion is to mount them on flannelette, felt, or velveteen. They will then adhere to a similarly covered stand. Write to your Provincial Department of Health.

— *Home Economics Newsletter*

PUBLIC HEALTH NURSING

Contributed by the Committee on Public Health Nursing of the Canadian Nurses' Association

The Practical Side of Evaluation

PHYLLIS E. (REEVE) BLACKALL

DURING THE last few years there has been a growing acceptance of evaluation by students, staff nurses, and supervisors in the Metropolitan Health Services in Greater Vancouver. We have been particularly interested in the evaluation of students who have come to us for field work in public health nursing from the University of British Columbia and have been experimenting with various methods and techniques for some time. We have also been trying to make good written evaluations of our staff nurses a part of the supervisory program. We want these reports to be useful; not only indispensable tools when making appointments, transfers, and promotions, but also to the supervisors in their guidance of the members of their staff. Since these two evaluation programs have been closely interrelated, we have learned something from each which has benefitted the other.

From where we stand now, several facts stand out. First, although it is more difficult to evaluate accurately the work and performance of a student who has a relatively short time with the agency, compared to the staff nurse, it is easier to write the evaluation. It is also easier to give constructive criticism. Perhaps this should not be so, but the fact remains that it is easier to be completely objective about a person one does not have to live and work with daily. At the same time, it is more satisfying to make a good evaluation of a staff nurse, to see it put to use, and to watch the nurse's continued development, than it is to write an evaluation of a student, and then not have the opportunity of watching the use she makes of it.

STUDENT EVALUATIONS

Because it is easier to write student evaluations we have obtained quicker results. Because we prefer to do things well or not at all, we have spent considerable time in studying theories and putting them to work. Ruth Freeman's book, "Techniques of Supervision in Public Health Nursing," has been invaluable, both for its philosophy and for its practical suggestions. Conferences with the nurses to whom students are assigned are held regularly. There is much free discussion regarding evaluation, its usefulness, its difficulties, methods, and so on. Sample evaluations are studied, actual cases discussed, and ideas exchanged among the nurses as to how to express themselves. How to criticize objectively, in ways the students will appreciate and not resent, is the part of evaluation brought up most frequently.

We believe that the evaluation should be objective; that it should be considered over a period of time; and that the opinions expressed in it must be based on facts as well as on general impressions. Therefore, each person having any student supervision to do is asked to keep written notes. These are used to gauge the student's progress and to illustrate the evaluation with concrete examples if any commendations, criticisms, or recommendations seem to require explanation. The Department of Nursing and Health at the university makes this note-keeping easy for us by providing an evaluation guide for each student. Most of the nurses keep notes in the appropriate sections of the guide and refer to them frequently during discussions.

We believe that evaluation is given primarily to help the student improve and strengthen her performance, not just to enable the university to follow her development. Therefore, we ask the nurses to give continuous verbal guidance all during the field work period. We also ask them to discuss the evaluation guide with their students, preferably midway through and again at the end of the period. Most of the nurses carry out the former, and many the latter suggestion very well. They do it so unobtrusively and tactfully that their students get a good deal of information regarding their strengths and their needs without realizing that what they are getting is good supervision and evaluation. The nurses find relationships easier if their students are more or less their own age, so we try to arrange this for them. It is not always possible, but one combination we can usually avoid is having an older student with a young, recently graduated nurse which sometimes leads to feelings of insecurity for the nurse.

We believe that supervision should be creative and that evaluation should follow through and be creative also. It is not always easy to maintain this attitude when discussing a student's performance or when writing an evaluation, especially if one has found it difficult to remain truly objective or has felt hypercritical toward the student. We try to remember always that we are not seeking to pour people into moulds, to make of them more creatures like ourselves, nor are we seeking to change or reform; rather we are trying to help people like ourselves, but having less experience perhaps, to perform effectively, using their own abilities in satisfactory (and satisfying) ways. We want to help them to realize their strengths and weaknesses, to face both with equanimity, to make good use of their assets and to make assets of their liabilities.

One point which is worth stressing is that an explanation is given to the students when they come to the agency of our objectives and methods of supervision and evaluation. This helps to remove from their minds the misgivings some students still seem to have regarding supervision.

In preparation for writing their evaluation, some of the nurses have found it helpful to have a conference with supervisors midway in the field work period, but anything more than informal discussions is not always possible. Conferences are held in each unit following the field work so that the senior nurse can integrate her findings with those of the other student supervisors. Participants usually bring their written notes to this conference. Some of the nurses like to have their evaluation already completed in rough form so that it can be read, criticized, and reconstructed if necessary. It is sometimes valuable at this time to have a discussion leader who has not had working contact with the student. She can often keep the discussion from getting side-tracked with unimportant detail, or from taking too much time—twenty minutes is usually sufficient for each evaluation. She can also help to keep discussion objective. She can say such things as, "I appreciate the fact that this student does not do things the way you like them done, but what results is she getting?" or "This student seems to have a good deal of knowledge at her fingertips. Does she put it over to families at their own level? Is she tolerant of other workers?" and so on. This objective discussion leader is particularly helpful with "difficult" evaluations, and no one will deny that there are such. Nearly all nurses appreciate help with ways of making criticism tactful and easy to take, and in following it up with practical constructive suggestions. We usually follow the guide in our discussions. The written evaluation is in narrative style, however, as this is freer and more readable than an itemized report. There is more scope for showing warmth and sincerity in a narrative piece of writing and these aspects are important.

One detail of evaluation we endeavor to avoid is the use of such phrases as: "Ability quite good, interest fairly good, performance quite good, etc." This phraseology can be of little use to the university or to the student, and is certainly of no value to a prospective employer. Instead of this we would probably write something like the following:

> This student shows average ability in teaching in homes and in child health centres, but is most adaptable in schools, where she shows an aptitude for work with elementary school children. While most of her interest lies in this part of the program she shows an eagerness to learn more of other phases of the work. She will need considerable supervision in tuberculosis visiting as her knowledge seems limited and contributes to her insecurity. With supervision and experience she should give an acceptable performance in any type of public health program.

There is one more step in our evaluation of students which we all appreciate. The personnel at the university, who receive the evaluations and discuss them with the students, let us know what they think of them. Sometimes the evaluations do not give as clear a picture as they might; sometimes there are important points missing. We are glad to know of these defects so we can avoid them another time. Sometimes we ask a nurse to rewrite or reword an evaluation before sending it to the university, but this is a rare occurrence.

STAFF NURSE EVALUATION

Our health service is made up of six health units, the nursing staff in each consisting of a supervisor and from five to fifteen staff nurses. In the central office there are the director of nurses and four consultants, including a nutritionist. The unit supervisors and the central office staff form our supervisory group which meets twice a month for purposes of study and discussion. This past year, we re-opened a long-term study of evaluation in order to add to our knowledge of it, to improve our attitudes, and also to adopt some reasonable form for the written evaluation. The fact that the supervisors have been helping the nurses write their student evaluations has taught us a good deal. Miss Freeman's book has, again, been invaluable, especially those chapters on Studying the Quality of Nursing Service, Techniques of Leadership, Observation of the Nurse in the Field, and Evaluation of Staff Performance. These we have studied and discussed in some detail, always trying to relate the theories to our own situations. We find that we can duplicate every example given by Miss Freeman and add a few more. We wonder if more adequate evaluation might not have avoided such things as leaving supervisory talent too long unrecognized, or having too little information from which to send to a prospective employer a recommendation for a former staff member. We select a different discussion leader for each chapter studied, and each leader brings up practical points for discussion. We have found our conferences so satisfactory that we intend to treat the remainder of the book in the same way, planning to spend the first hour of alternate supervisors' meetings in studying ways of overcoming our own difficulties.

We have been wondering for some time in what order we should write our evaluations. Now, having found the university's guide so successful in fulfilling its purpose, we have drawn up a similar modified guide, the outline of which is included, here, for our own use. We follow this using a free, narrative style, illustrated with examples taken from the supervisory record. (On a form drawn up for the purpose, the supervisor plans her visits to and with

Guide for Writing an Evaluation of a Staff Nurse

I *General Impression:*

- **(a) Personal qualifications — Reliability, adaptability, appearance, judgment, resourcefulness, manner, punctuality, interest, sincerity, sense of responsibility, health, etc.**
- **(b) Social vision.**
- **(c) Professional and community activities.**

II *Performance:*

- **(a) Approach to lay individuals and groups.
Approach to professional individuals and groups.**
- **(b) Relationships with parents, children, teachers, private physicians, staff and other workers.**
- **(c) Organization and planning.**
- **(d) Recognition and analysis of problems.**
- **(e) Teaching — Subject matter, methods, results.**
- **(f) Records.**
- **(g) Student program.**

III *Progress and Recommendations:* (Be specific)

each nurse. Progress notes are kept on what the supervisor observes and the plan modified according to the nurse's needs.) We have more detailed guides which are really a series of questions concerning various phases of our work. These stimulate the supervisors' thinking and act as reminders. Although they are too detailed to be followed exactly, they prevent some parts of the work being stressed to the exclusion of others.

New staff nurses are made aware of the type of supervision and evaluation we are trying to carry out, when they are first introduced to the agency. Also, we include the question guides in our work manuals which are available to all nurses in their schools, child health centres, and unit offices, so that they may know in detail what is expected of them and along what lines they are being appraised, and can evaluate their own performance. Because of this and because of the work being done along these lines in universities, we find that our younger staff members, almost without exception, accept and welcome evaluation. The reaction of older staff members who have never seen, until recently, written evaluations of their work, varies from complete acceptance to rejection. We respect both reactions and have not made reading the evaluation compulsory.

In preparing evaluations we all find similar difficulties confronting us, i.e., how much to say, what to say and how to say it, how to be helpful, how to criticize constructively, how to be objective and, at the same time, warm and sincere; how to create strengths where there are weaknesses and, of course, how to find time for it all. Feeling that we could help one another with some of these difficulties we decided to get down to actual cases rather than hypothetical ones. Each of the unit supervisors agreed to write an evaluation of one of her staff nurses, calling her Miss X, and to bring it to a meeting to be studied from the point of view of length, completeness, value to an employer or supervisor, acceptability and usefulness as far as the nurse is concerned, etc. This experiment is only beginning, but we can see already that it has practical possibilities.

We do not expect perfection in anything so difficult as evaluation because we realize we are all human beings in whom perfection is an impossible goal. We feel we must approach each evaluation with humility for our own right to evaluate and respect for the person to be evaluated. We still have to fight a reluctance which many of us feel—to put our findings down in black and white for someone to read, and perhaps object to, before signing. However, we are overcoming this reluctance and it is becoming easier to convince nurses that we are not sitting in judgment, one person on another, when we appraise them and record our findings. As supervisors, we realize that we have accepted a responsibility to help others achieve quality and satisfaction in their work through evaluation.

Enuresis

NORA TILLSON

> I may exaggerate, I hope I do, for where there is no exaggeration there is no love and where there is no love there is no understanding. It is only about the things which do not interest one that one can give an unbiased opinion; and this is no doubt the reason why an unbiased opinion is valueless.
>
> — *Biography of* OSCAR WILDE

I quote this as an alibi for I know that I have been guilty of wishful thinking, over-optimism, in pursuing the subject of the prevention and cure of enuresis.

Bed-wetting has been a source of endless work and worry to mothers, mortification and discouragement to the victims. It is one of those things which has only been mentioned in whispers, and, until I embarked on this project, I had no conception of its prevalence or the unhappiness which it entails.

Several years ago a boy of fourteen was brought to the school doctor for help. He wanted very badly to go to camp but was unable to do so because of enuresis. The advice given was to restrict fluids after supper, and to get him up often enough to keep him dry and, because of his age, to make him assume the responsibility for getting himself up with the help of an alarm clock. He did not go to camp!

This incident nettled me, but I could find nothing of help on the subject until I read in a book on psychology that for one case of bed-wetting due to disease, there were nine attributable to psychological causes. The psychological factor underlying enuresis was said to be a loss of feeling of security. (I leave the problem of disease to more competent authorities and pursue my own theory.)

With the above knowledge as a starting point, a new idea began to take shape. When I ran across three cases of enuresis within a short time, I was rash enough to ask the mothers to try an experiment:

1. To have the urine checked to eliminate the possibility of disease.
2. Restrict fluids after supper.
3. To get child up often enough to keep him dry and while doing so to be gentle and show affection.

These mothers reported back some time later that the plan had worked and the children were cured. Further confirmation of my theory came from another mother who had observed that her daughter never wet the bed when she occasionally slept with her.

This initial success made me want to pursue the study more intensively and I outlined my ideas to the provincial supervisor with a view to getting permission to proceed. During the discussion she said, "If you are able to cure it you should be able to prevent it." Thus a new angle that was definitely intriguing was introduced.

During home visits I purposely tell mothers about the work I am doing with enuresis. This serves to locate new cases, to promote discussion of allied troubles and, by showing contributing factors, to try to prevent the occurrence of it in that home.

SUMMARY OF RESULTS IN 63 CASES

Cured	33
Controlled by getting up once	11
Controlled by getting up twice	3

Children too young to expect control	5
Moved and so lost track of	3
Progress not yet known	4
Apparently not helped	4

SUMMARY OF POSSIBLE CAUSES

Disease	2
Pin worms	4
Fear	5
Mother in hospital	1
Suppressed anger	1
Stress of strain in family life	12
Jealousies	38

The first step in dealing with enuresis is to learn the family set-up, number of children, where the child in question fits in, explaining to the mother that 90 per cent of this trouble is due to psychological factors. I try to get the history of the trouble. Was the child ever controlled? When the control was broken, what happened at that time that might account for it? It is essential to get it across to the mother that bed-wetting occurs when the child is asleep and, therefore, no blame should be attached to him.

The child should be given plenty of fluids during the day but restricted at supper time and nothing afterwards.

A system of getting up is planned with about a three-hour interval, this to be regulated according to individual need. If at one specific time the child does not need to get up, and this occurs for two or three consecutive nights, omit that time and so on until one getting up is sufficient to keep him dry.

These children are quite quickly controlled and in the first flush of success the mother may stop getting the child up. I feel there is danger in this, and that if child breaks control again, the second time it is harder to get results. Getting the child up at the time the mother goes to bed should be continued for some time. Each time the child is roused an opportunity is given for showing affection in some way, thereby giving him that extra attention he craves and needs.

The fact which seems to arrest the mother's attention is that enuresis can and does occur from such a simple and normal happening as the advent of a new baby into the home. The following case histories will illustrate the types of problems which may be encountered:

Mary Barbara, at two years of age, was taken to hospital to have a cleft palate repaired. She had been toilet trained by then but when she returned home she had broken control. At four years she was placed under a child specialist and two years later she was still not trained. I came in touch with her at the time of her complete physical examination on starting school. In three weeks she was controlled and I assumed she was cured. Some months later I met her mother and she told me that Barbara was in difficulty again, that she had developed diseased tonsils and her hearing was affected. She has since had a tonsillectomy, resulting in improved hearing. She is not improved otherwise. The mother feels that she should drop all efforts in this regard for a time, then consult family doctor for help. This seems sensible to me as there has been possibly too much attention given already.

This case illustrates *strain:* Earl is seven. For the first three visits I seemed to get nowhere with his mother. On the fourth, I felt I had her undivided attention for the first time. There are three children — a boy of nineteen, a girl of sixteen, and Earl. The mother and father are very energetic and so is the daughter. The two boys are slow both mentally and physically. As a result they had to be dressed and fed long after they should have been able to care for themselves. There are aunts and uncles on both sides of the family who are better off financially and whose children are quicker at school. There has been considerable rivalry as a result and corresponding stress to the two boys. Earl has never been controlled. The first boy is very dependent on his mother. Getting a job, he loses it because he will not get up early enough to get to work on time.

There may have been some complication of fear in Earl as well as stress, fear of going up to bed alone. His bedroom is upstairs while his parents sleep down. As part of treatment on going to bed he is put in his parents' room and when they wish to retire he is taken to the toilet and put upstairs. He is now controlled after eight months.

His disposition has improved and his personality is developing.

This is another instance of *strain*: Richard is three. His mother asked me in clinic if it was merely coincidence or if it could be possible that his bed-wetting could result from his grandmother's presence. It stopped when she left. She was much too critical, scolding and nagging the child.

Carol is four, another case of *strain*. There are three children. Deserted by her husband, the mother was forced to come to her mother's home, making eleven persons living in four rooms. It was suggested that she restrict fluids after 6 p.m., get the child up so as to keep her dry and give her extra loving. I felt rather hopeless about this situation and was indeed astonished when in two weeks the child was cured.

The one case of disease was a boy of eleven. An examination of the urine showed excessive acidity. He had some difficulty during the day in control of the bladder also. After medical treatment for the bladder trouble, his enuresis ceased.

Suppressed anger: Grant was aged eight. This boy's mother heard me talk about enuresis to a group of women. I went to the home about four weeks later, because Grant was reported ill in hospital. There was very little discussion about that. The talk centred on the fact that he had been cleared of his enuresis before having to be hospitalized. The story was that the mother began to study the boy after my talk and realized a rather amazing fact. When the time came for Grant to go to bed he was told to do so. He complied without fuss but showed resentment. He invariably wet the bed. When given ten minutes warning he went up without anger and the trouble was cured. He did not break control while he was away and he was very ill. I wonder if you can imagine the mother's pride in her boy.

Jealousy: You will note the large percentage of cases occur under the heading of jealousies. James, aged three, started wetting the bed after his mother came home from hospital with a new baby. I learned about him in making an infant welfare call. He was cured very quickly with the routine treatment of restricted fluids after six, getting up as required, and that extra loving so needed.

Gordon, aged eight. This boy's mother had to go to hospital a year and a half ago. When she returned Gordon had started wetting the bed. I picked this case up in making a call for another reason. I explained treatment and returned a month later to discover that Gordon had had no further trouble since my first visit. It seems his mother had had a habit of saying to him when he came up close to her, "You know you are my favorite, Gordon." She forgot to do this on her return from hospital. The first night when she got him up around eleven, she said this to him and, looking up in surprise, Gordon said, "Am I mother? I thought it was Johnnie." He has not broken control since. He started waking himself at night, first twice and now only once.

There are five children under the age of three. I have made visits to the homes but have warned mothers not to try too hard to cure this yet. Psychologists state that children can be harmed by too early habit training and I am not sure of what is considered too early. Wayne is not three until March. This child was referred to me by his family doctor. He had, for some unknown reason, become afraid of the toilet. With the lure of a new book given only when he was using the toilet, the fear was overcome. Wayne cleared for a time but relapsed when he took a cold. On the whole there is improvement but again I stress the fact that training may have been started too soon.

Almost every visit produces other facets of emotional needs. If any public health nurses are feeling bored with their work I can promise them a renewed interest, a project which brings great satisfaction and happiness.

Year End Thoughts

He has achieved success who has lived well, laughed often and loved much; who has gained the respect of intelligent men and the love of little children; who has filled his niche and accomplished his task; who has left the world better than he found it, whether by an improved poppy, a perfect poem or a rescued soul; who has never lacked appreciation of earth's beauty or failed to express it; who has looked for the best in others and given the best he had; whose memory is a benediction.

INSTITUTIONAL NURSING

Contributed by the Committee on Institutional Nursing of the Canadian Nurses' Association

A Study of Isolation Technique

CLARA R. AITKENHEAD

THE Committee on Instruction of the Province of Quebec became inspired to review nursing procedures relating to isolation technique as a result of the confusion arising in the minds of student nurses, especially those who had affiliated from smaller schools, regarding the effectiveness of various methods and disinfectants employed, as well as desirable strengths of solutions and length of time required for safe disinfection. This important subject was discussed under four headings: (1) safety; (2) efficiency; (3) simplicity; (4) uniformity.

The committee is indebted to Dr. Frederick Smith, Dean of Medicine, McGill University, formerly professor of bacteriology, who is keenly interested in nursing techniques. Dr. Smith contributed very generously of his time in giving advice and making recommendations.

The complete technique was discussed from a broad point of view, allowing some flexibility in order to be practical and applicable in hospital or home. The solutions recommended were those commonly found in most hospitals. Emphasis was placed on cleansing, strength of disinfectant, and length of time necessary for safe disinfection. This study stimulated keen interest among instructors and supervisors, and represents the result of excellent group participation.

PROPOSED PROCEDURES

LINEN—*in hospital:* Put through laundry and washed the same as ordinary linen. Temperature of water should be 165°F.

LINEN—*in the home:* Immerse in water and bring to boiling point. Then can be washed or sent out to laundry.

As a precaution for those handling the linen from ward to laundry, contaminated linen should be put in a specially marked bag, untied when ready to be washed, linen put into washing-machine by holding outside corners of bag, and dropping contents into machine. The outside of this bag should not be contaminated. Linen from the beds of patients with active tuberculosis, or with venereal disease when there is a discharge present, should be considered contaminated. Linen from pneumonia patients need not be separated. Linen from infants with congenital syphilis with open lesions or nasal discharge should be treated as contaminated. If linen is grossly contaminated with urine or feces, as in typhoid fever, it should be soaked in either Izol 2%, Lysol 2%, Creosol 2%, or Formalin 10%, and allowed to soak, fully immersed in the solution, for one hour. It can then be rinsed and sent to laundry. Chloride of Lime is not recommended. It is not always dependable due to uncertainty regarding freshness.

WOOLLEN BED BLANKETS: Cannot

be disinfected by washing since too hot water destroys them. Could be autoclaved but this is also hard on wool. Not considered grossly contaminated since they are protected by spread and top sheet; therefore should be sent through with regular laundry inside a marked bag (stating they are woollen blankets). This is considered sufficient. Exposure of woollen blankets to special ultra-violet ray lamps will not disinfect them. Flannelette blankets are recommended instead of woollen ones.

MATTRESSES AND PILLOWS: Cannot be disinfected by airing or use of chemical disinfectants. Can only be done safely in a mattress sterilizer. Not considered grossly contaminated since more protection is afforded by mattress cover or pad and bottom sheet. Bed rubber also protects mattress. Pillows used for tuberculosis patients could be autoclaved.

DISHES: Scraped and cleansed of food with paper napkin as clean as possible—immersed in water with tight-fitting cover on container, and allowed to boil for three minutes. Then washed in hot soapy water and rinsed in very hot water. Towels for drying dishes should be scrupulously clean, otherwise disinfection is of little, if any, value. If hot enough water is used to rinse dishes, it is better to allow them to dry without use of towels. Small sterilizers for use on wards are available for disinfection of dishes.

ENAMELLED WARE: When cleansed, immerse in water and boil for three minutes, same as dishes.

GOWNS: Should be changed when soiled, or once daily.

BOOKS: Impossible to disinfect. Destroy.

STOOL AND URINE—*from typhoid fever and other intestinal diseases:* Covered with an equal amount of either Izol 2%, Lysol 2%, Creosol 2%, or Formalin 10% and allowed to stand for one hour before being discarded down toilet or hopper. The disinfectant should be well mixed with the feces which has been broken down as much as possible. Chloride of Lime is not recommended as a disinfectant unless it is known to be absolutely fresh.

BATH WATER—*from typhoid fever patients:* If not grossly contaminated from urine or feces, considered satisfactory to pour down hopper or toilet. If grossly contaminated, treat same as urine and feces.

MASKS: If a mask is once removed from the face it should not be reapplied but a clean one substituted. If plastic masks are used each person should keep his own, washing it in green soap and water.

POST-CARDS: Patients should write cards instead of letters. If patient's hands are clean and he writes cards on a clean surface and avoids droplet infection, they should be safe for mailing. Cards written by active tuberculosis patients should be autoclaved. Cards, letters, and magazines which patient has received while isolated should be burned when he is taken out of isolation.

PURE RUBBER: May be disinfected by boiling for five minutes. Boiling is satisfactory for Levine tube provided water is allowed to run through tube.

SHEET RUBBER: Rinsed well in cold water, then immersed in water tested with thermometer—at 165°F. When this water has cooled sufficiently, wash rubber well, using soap, then rinse well under running cold water and dry thoroughly. This is considered sufficient for rubber sheets used after any disease.

CLINICAL THERMOMETERS: Individual thermometers, or one thermometer per patient essential. If kept in individual containers it is satisfactory to keep them in plain water which is changed daily. If not kept in individual containers, then there should be sufficient thermometers to go around all patients so that disinfection between patients is not necessary at time of taking temperatures. *Thorough cleansing* of thermometer with soft tissue before immersing in disinfectant solution is stressed.

Method suggested when thermometers are not kept in individual containers: Have sufficient thermometers for number of patients (one for each patient) which have been disinfected and, therefore, need not be kept in any solution. When thermometer is removed from mouth it should be cleansed well with soft tissue to free of mucus, immersed in a soapy solution—then, when all temperatures have been taken, cleansed thoroughly in a soapy solution, immersed in carbolic solution 5%, and allowed to stand in this for one hour. Then they should be rinsed thoroughly in cold water, dried, and stored safely in covered container. Lysol 2% or Formalin 2% might be used as disinfectant. This thermometer technique is recommended for use in general hospitals.

CONCURRENT DISINFECTION OF ROOM—*Furniture:* Damp dusting daily. *Floor:* Sprinkled with chemically treated "sawdust" which prevents dust from rising, then swept with brush. In a general hospital, keep brush and dustpan in room during period of isolation. If floor is grossly contaminated it should be washed immediately. Floor may be swept with gown on, this gown being discarded immediately after in exchange for a clean one.

TERMINAL DISINFECTION OF ROOM: Should be left for half a day if possible, before attempt is made to clean it, to allow dust to settle. Following respiratory diseases, ceiling and walls should be washed. Special ultraviolet ray lamps are available for disinfecting rooms—exposure one half-hour. (It is not recommended that woollen bed blankets be exposed to this lamp for disinfection due to lack of penetration.) *Furniture:* Wash well with soap and water, dry. *Floor:* Washed. Brush and dustpan washed and dried.

Expansion of Clinical Facilities

HELEN E. PENHALE

THE EXPANSION of clinical facilities is just another way of saying that we must endeavor to provide more nursing service for the public. One of the foremost objectives of postwar social reconstruction is the organization in the very near future of a truly comprehensive service for the nation.

The present shortage of nurses is due to a combination of factors. There has been a constant development of new forms of health service; more and more is being done for the health of the people, and more and more hands are needed to do it. Pre-payment plans for hospitalization and the new maternity act are but two of these forms of service here in Alberta. More hospital beds are occupied now than before the war. In 1929, Alberta had 3,724 beds or 5.7 per thousand population. In 1945, we had 6,178 beds or 7.4 per thousand. Patient days have steadily risen from 807,894 in 1929 to 1,499,029 in 1945. This means that today more hospital beds are occupied than ever before, and still hundreds of patients await admission. There are demands for nurses in other fields—industry, public health, etc. Many of the nurses who came out of retirement, or who postponed retirement, to help during the emergency in the past few years have now retired to enjoy a well-earned rest. There is a vicious circle in the shortage itself. A short-handed staff means an overworked staff and strained working conditions. Thus wrong impressions of the real nature of hospital life and work are created and people are discouraged from choosing nursing as a career. To date, recruitment has not fallen off in Canada. This is not the case in the United States. Even in the best schools recruitment has fallen off, in one school from 60 down to 12!

We say we have not enough nurses. How many do we need? The ratio of nurses to population, as estimated by Dr. Thomas Parran, surgeon general, U.S.P.H.S., is 1 to 285. Enough nurses means that we would not only administer the necessary nursing care to the sick but would also be able to carry on a full preventive and positive health program. Do we in Canada have a ratio of 1: 285? British Columbia has 1: 234, Saskatchewan 1: 579, Canada as a whole 1: 350, and the U.S. 1: 400. In Alberta we need 786,000 (estimated pop.) ÷ 285 = 2,758 nurses.

Our present resources include those in active membership (1946, A.A.R.N.), 1,860, temporary permits, 109, for a total of 1,969, or a shortage of 789 nurses below the desirable minimum. Where are we to get this needed 789 nurses? Our annual loss of nurses from nursing is greater than our gain from new graduates and nurses coming into the province from elsewhere. Our existing resources just cannot fill our needs. Let us look at our annual membership for 1946:

Annual renewals, 1,441.

Annual membership increase (1946 graduates), 262; annual membership increase (prior to 1946), 18; reciprocal registrants, 139; totalling 419, with a grand total of 1,860.

Annual exemptions, 504, made up of such causes as: Marriage, 265; illness, 13; residence outside Alberta, 213; retirement, 9; unclassified, 4.

Thus, in 1946 we had 85 more exemptions than new members.

In order to continue to provide 262 graduates each year, each school of nursing in the province must be used to capacity. Methods of selection of students, even though made with extreme care, still leave us with a loss of 12.5 per cent in Ontario, from 30-70 per cent in Great Britain, and for Canada as a whole 15.56 per cent. The survey conducted by Dr. and Mrs. Bixler in Michigan indicated that poor scholarship accounted for the greatest part of the loss. Our methods of selection will have to be improved now that Alberta has a new educational standard unless we accept as our standard for nursing anything that is "warm and walking." It seems obvious that our present facilities, even if taxed to their utmost, cannot meet the need.

Is it possible to import nurses? In 1946, 7 per cent of the total nursing membership were reciprocal registrants—a total of 139.

Does the answer lie in opening more schools? The majority of the smaller hospitals do not offer a sufficiently varied experience to the students. The Weir survey suggested that all schools be closed that were connected with hospitals of less than 75 beds and a daily patient average of under 50.

The preparation of another type of worker will help to a degree. The training of nursing aides is well established in most parts of Canada. There are more than fifty schools in the United States with some degree of legal control for this group in twenty states. In Alberta, this type of worker spends 10 months in preparation—3 months of theoretical instruction, 3 blocks of 2 months each of practical experience in general, tuberculosis, mental, and/or chronic hospitals, and a final month at the school for review and examinations. She is prepared to give care to the sub-acutely ill, the convalescent, and chronically ill who require nursing service at home or in institutions. She will work under the direction of a licensed physician or a registered professional nurse. There are specific controls and limitations of her activities. Both the public and the professional nurse have been protected through legislation set up to control this group.

During the past year the Alberta Educational Policy Committee has been studying the possibilities of preparing more students through setting up affiliations in tuberculosis and psychiatric nursing. The possibility of using rural hospitals for internships has been studied. We have obtained a great deal of information from other provinces and from south of the border. A suggested affiliation contract and tentative course outlines have been set up covering the experience in each of the three areas—tuberculosis, psychiatry, and rural hospitals. At a meeting of representatives of hospitals, schools of nursing, etc., held in April, 1947, a resolution was passed that the A.A.

R.N. send to the chairmen of hospital boards a brief covering the reasons for affiliation and encouraging their co-operation. The committee plans to continue the study and before too long we hope our students will have affiliations in each of these services.

The academic requirements for admission to schools of nursing in Alberta have been subjected to revision. With this comes the necessity to review the Regulations Governing Schools of Nursing in Alberta. The regulations were last reviewed in 1943. An adjustment of these regulations and the increasing of clinical facilities still does not begin to solve the shortage to which we referred.

Another factor we must consider is the nurse of today. A decade ago, the nurse was trained primarily to give care to the physically ill. Today, she must be prepared to provide additional functions. She interprets to the patient the discoveries of medical science and the place of the hospital in the field of health promotion. She serves as one of the many health workers engaged in programs for the prevention of disease and promotion of health. Finally, she teaches the use of personal health measures and community resources. Nursing education must be in accord with the type of service the public expects nurses to render. The plan of educating nurses by requiring them to pay for the greater part of their education by their services will have to be changed before nursing education can attain the ideals of a sound profession. The time has passed when we can look back and reminisce about the good old days. Reminiscing leaves only a sentimental glow that casts no light on the path ahead. The majority of the students in our 169 hospital schools across Canada are in schools financed, controlled, and maintained by hospital boards. The patients in these hospitals should not be expected to pay for nursing education in their hospital bills. Nor should the student's education be sacrificed while she provides nursing service for the hospital. If we continue to exploit her, her education and future contribution to the health of the nation is jeopardized.

A different type of nursing education is being considered—in fact many new ideas are being presented as the way out of our present dilemma. As a project to improve nursing education in this province, the Central School of Nursing is being studied. This is not a new idea. Isabel Hampton Robb talked of it fifty years ago. She proposed it as a means of increasing enrolment in schools of nursing and as a means of improving standards. By 1941, there were nineteen centralized teaching programs and five central schools in the United States. A centralized teaching program, covering the preclinical period, was discussed in this province in 1940. The planning committee does not advocate this form of centralized teaching program now. It implied a program which centralized part of the instruction for a definite period of time, for example, four months. We are advocating a *Central School of Nursing*, one whose administrative and educational personnel are organized so as to constitute an educational entity, and where the students' clinical experience is secured in more than one hospital and additional agencies.

There seem to be many advantages to this plan. They are:

> Improved instruction in schools connected with small hospitals; more adequate instruction ensured in the basic sciences; more standardized education for all students in all schools in a given area; better nursing services for the sick; more economical use of available qualified nurse instructors and lecturers required for student nurses in a given area; saving of classroom equipment; increased number of qualified nurses to meet the demands of a national crisis; more highly qualified instructors; wider clinical nursing experience for the student; improved standards of the participating hospitals; keener student competition; an improved curriculum.

Further meetings are planned when the subject will be gone into in detail and it is to be hoped that we can proceed eventually with a plan for a Central School of Nursing.

AUX INFIRMIÈRES CANADIENNES-FRANÇAISES

Une Question

Chères Compagnes:

Décembre est le mois où l'on échange des lettres. Je ne veux pas laisser finir l'année sans vous écrire un mot. Je m'adresse à toutes les infirmières — aux religieuses, directrices, institutrices, hospitalières, qui, chez nous, assument la responsabilité de la formation de l'infirmière; aux infirmières diplômées des hôpitaux qui contribuent elles aussi à la formation des élèves.

Je m'adresse aux infirmières du service privé dont les intérêts économiques sont instables et souvent menacés et aux infirmières hygiénistes dont j'admire tant le dévouement et le patriotisme. Je m'adresse à celles qui sont isolées comme à celles formant un groupe bien uni. Je m'adresse à toutes les infirmières, même à celles qui ne le sont qu'en herbe, aux élèves de nos hôpitaux.

L'Association des Infirmières du Canada publie un journal officiel intitulé *The Canadian Nurse.* Dans ce journal sont publiées les activités importantes des neuf associations provinciales; l'on y rapporte aussi des faits se passant dans d'autres pays, susceptibles d'intéresser les infirmières.

La valeur des renseignements donnés dans cette revue, la nécessité toujours de plus en plus grande de se tenir au courant des choses de notre profession ont déterminé nos représentantes à l'Association des Infirmières du Canada de demander au conseil de publier en français les notes du secrétariat et un article également dans notre langue.

Le but de cette demande était de permettre aux infirmières de langue française de se renseigner sur la politique de l'Association des Infirmières du Canada et aussi sur celles des autres provinces. Pour atteindre ce but, depuis avril 1946, tous les mois, les notes du secrétariat ont été traduites et un article en français a paru.

La question des aides a été longuement étudiée; celle des conditions de travail dans les autres provinces du Canada et dans d'autres pays ont été rapportés dans les notes du secrétariat.

En quinze minutes de lecture, l'infirmière peut se rendre compte des études, à l'ordre du jour et des faits pouvant avoir des répercussions, non seulement sur la profession en général mais pouvant affecter sa manière de penser et de vivre.

Pour être renseignée, il faut nécessairement prendre connaissance des faits concernant l'objet de notre intérêt. Je me demande si les infirmières de langue française sont renseignées sur la profession d'infirmière au Canada. Par le nombre d'abonnées à la revue, soit 81, je serais tentée de répondre: "Non."

Notre profession, comme le monde actuel, est à un tournant. Il semble nécessaire, plus que jamais, que chacune d'entre nous soit renseignée et se fasse une opinion.

Chères compagnes, je viens vous demander si vous désirez la continuation de ces pages françaises. Sont-elles utiles à vos élèves lors de l'enseignement des problèmes et de la politique de la profession? Y trouvez-vous de la matière pour les conférences des hospitalières, pour les réunions des amicales, et pour les assemblées des infirmières de districts?

Dans la lecture, en particulier, de ces pages, infirmières du service privé, vous tenez-vous au courant des événements? A toutes, je demande une réponse, qu'elle soit affirmative et concrète, je la souhaite, mais quelle qu'elle soit, faites moi connaître votre opinion en toute sincérité.

Cette revue n'a pas la prétention d'être parfaite, ni de répondre à tous les besoins des infirmières, mais elle répond à certains besoins et donne certains renseignements officiels qu'il est impossible de trouver ailleurs.

Nos pages françaises vont-elles mourir avec la vieille année ou renaître avec le nouvel an? Une vie de plus vous est confiée, qu'en ferez-vous?

Je termine cette longue lettre, chères compagnes, en vous offrant tous mes voeux de Joyeux Noël. Soyez heureuses . . . que l'année soit bonne pour chacune d'entre vous . . . et que le Bon Dieu vous donne le Paradis à la fin de vos jours.

Sincèrement vôtre,

SUZANNE GIROUX

Arthritis

Around the Council Table

[Members and advisers of the interim committee of the Canadian Arthritis and Rheumatism Society, organized recently in Ottawa, get down to work. Left to right around the table are: Dr. H. A. Ansley, Ottawa, assistant director of health services, Department of National Health and Welfare; Dr. R. Dandurand, associate professor of medicine, University of Montreal; Dr. J. B. Collip, London, Ont., dean of medicine, University of Western Ontario, and director of medical research, National Research Council; Dr. G. D. W. Cameron, Ottawa, Deputy Minister of National Health; Dr. Wallace Graham, Toronto, Canadian Rheumatism Association; Hon. Paul Martin, Minister of National Health and Welfare; Sir Andrew Davidson, chief medical officer for Scotland; Dr. T. C. Routley, Toronto, general secretary, Canadian Medical Association; Dr. F. W. Jackson, Winnipeg, Deputy Minister of Health and Public Welfare for Manitoba; Miss Ethel M. Cryderman, Toronto, first vice-president, Canadian Nurses' Association; and J. S. L. Browne, faculty of medicine, McGill University, Montreal.

A few of the pertinent data regarding arthritis will indicate how important the work of this committee is. A booklet issued by the Greater Vancouver Health League indicates that for every case of tuberculosis there are ten of arthritis; one heart case to two of arthritis; one of diabetes to ten and one of cancer to seven of arthritis.

The average age of arthritis sufferers is forty-one years. The average age of those permanently crippled is fifty-five years.

Arthritis accounts for a greater number of days lost from work than any other chronic ailment except nervous and mental diseases.

Notes from National Office

No Racial Discrimination

IT HAS BEEN brought to the attention of the Canadian Nurses' Association, through the medium of the press, that the National Council of the Young Women's Christian Association conducted a survey among schools of nursing in Canada on the question of racial discrimination. The results of this survey have been published in various papers across Canada. It appears wise and timely that all nurses, as well as others, should know the policy of the Canadian Nurses' Association concerning racial discrimination, which is as follows:

> The Canadian Nurses' Association in general meeting, June, 1944, again reaffirms its policy concerning racial discrimination by resolution:
>
> WHEREAS, It has been brought to the attention of the Executive of the Canadian Nurses' Association that certain racial discriminations are practised in some Canadian schools of nursing, therefore be it
>
> *Resolved*, That the Canadian Nurses' Association, at this 22nd biennial convention held in Winnipeg in 1944, reaffirm its policy to support the principle that there be no discrimination in the selection of students for enrolment into schools of nursing.

This resolution was unanimously adopted.

Obtaining Information

During the past few months, several questionnaires have been circulated to the schools of nursing in Canada for the purpose of securing explicit information. This information is being sought by the Department of National Health and Welfare which has requested data concerning the nursing personnel of Canada, with special emphasis on the maximum potentialities for training additional student nurses. Facilities for training subsidiary workers are also being clarified.

Another questionnaire seeks to gain a true picture of the present shortages in general staff, head nurses, supervisors and instructors in our schools of nursing and other hospitals, including tuberculosis sanatoria and mental hospitals. Similar data are being secured for public health nursing services.

The third topic of interest is a study of the number of student nurses who withdraw from training and the reasons for these withdrawals. In order to facilitate reporting and to provide comparable data, the directors of the schools of nursing are being asked to record the information for future classification. Where withdrawal appears to be due to more than one reason, the *predominant* cause is to be recorded. The following list forms the basis of this problem in nursing research:

1. Failure in class work.
2. Failure in clinical practice.
3. Failure to meet school's regulations and social standards.
4. Immaturity.
5. Health.
6. Personality and temperament unsuitable for nursing.
7. Disappointment in nursing course.
8. Dislike for nursing.
9. Matrimony.
10. Personal reasons: Family complications, death in family, homesickness, pregnancy, financial reasons, decision to go to college.
11. Other reasons: Specify.

National League of Nursing Education

The 51st annual convention of this body was held in Seattle, Wash., September 8-11, 1947. Miss Evelyn Mallory, Vancouver, second vice-president of the Canadian Nurses' Association, represented us on this occasion. Miss Mallory, in collaboration with Miss Alice L. Wright, executive secretary, R.N.A.B.C., has prepared a most interesting and stimulating report on the proceedings for presentation to the Executive Committee, C.N.A. Space precludes the possibility of printing this entire report but many of the highlights follow:

To be able to attend this meeting at which were present so many of the leaders in the field of nursing education in the United States and to hear them discuss their problems was a very stimulating experience and a most enjoyable one for me personally. I returned feeling that I had attended an institute planned to meet my own specific needs; that our thinking here in Canada is very similar to that of our neighbors; and that Canadian nurses owe much to the League. For years we have made extensive use of their studies and we shall no doubt continue to do so. We modify them to meet our own needs, but the basic ideas are often essentially theirs. I sometimes wonder if we might not make more effort for ourselves if we did not have that valuable source of help so close at hand. I came home firmly convinced that we in Canada have no counterpart to the National League of Nursing Education and that we need one badly.

A minimum amount of time on the total program was devoted to a consideration of *routine reports.* At the opening business session on Monday morning the reports of officers, committee chairmen, etc., were accepted as recorded in the printed booklet given to each nurse as she registered. This undoubtedly facilitated the submission of reports but did not encourage discussion or questioning. Though it was possible to obtain these reports by registering on Sunday, one felt that very few nurses had read them or were very familiar with their content.

Program: The total program was very aptly entitled "Nursing Education for Public Service." Topics were presented by means of panels, round tables, symposia, and by special speakers, all experienced in the various fields on which they spoke.

Public relations: In public relations Mr. Byron Christian pointed out that the field of public relations has just grown, that it developed first in business but has now spread to practically all other activities. He gave various interpretations of the meaning of "public relations" such as, it is the business of getting along with people. It is being good and getting credit for it! It is 90 per cent doing right and 10 per cent talking about it! It is a planned program of policies and conduct which will build public confidence and increase public understanding.

The aim should be to win friends (for the organization or the service) on a permanent basis. A planned program is essential but, in the planning, policies and conduct are of the utmost importance. What is needed is not propagandists but persons who will inform the public truthfully of what we have to offer.

Participants in the symposium that followed emphasized that public relations in the school of nursing is a two-way process, that is, we need better public relations to attract desirable applicants and it is within the power of the school of nursing to produce graduate nurses who will themselves sell the product to the public.

Student nurse recruitment: One speaker stated that today women have twenty thousand jobs to choose from and that nursing education is competing with many other fields for the upper 10 per cent of the group graduating from high school. Possibly nurses are over-emphasizing the special fields and planning for tomorrow, thereby neglecting the needs for general bedside care for those in hospital today. She advocated putting more emphasis on the service aspect of nursing because the ideal of service appeals to young girls. Another speaker advocated not charging tuition fees but paying allowances. The A.H.A. urges the elimination of all legal requirements in relation to age.

Nursing education and its relation to general education: Dr. Eldon Johnson, of the University of Oregon, stated that we must ask ourselves what is the proper relationship between a liberal and professional education; what factors are needed to strike a happy balance. He said we need more emphasis on social science, the humanities. We need education for life as well as education for livelihood.

Dean Margaret Tracy, of the University of California, said that our major concern is for better nursing education and our major problem is how to get it. She mentioned the tremendous range in the size of hospitals operating schools of nursing. Do we know what size of hospital will give the best preparation? What size of student body will result in the best preparation and what size is most economical from the standpoint of nursing education? Miss Tracy put the question: How can research help us? She said, "Research is a high-hat word that scares people." It means going out and looking for change instead of waiting for change to come to us.

Dr. Esther Lucille Brown's "Progress Report on the Study of Schools of Nursing" was the highlight of the whole convention. Dr. Brown said that her observations thus far had led her to certain conclusions in relation to nursing: (1) Hospitals require terrifically large staffs. (2) As research continues the type of service required becomes increasingly complex in nature. She listed eleven implications for nursing and outlined new patterns of nursing education that must emerge therefrom. Some of her points were:

There is a noticeable trend for doctors to delegate more responsibility to nurses. Nurses carry the responsibility for the care of the acutely ill. Curative care is eating up funds and restricting the development of preventive programs. Nurses should not waste their energies in tasks that can be performed by attendants and practical nurses. In conclusion Dr. Brown felt that when one considers the activities and responsibilities of the professional nurse it is very evident that a high school education is not sufficient. She needs to have the ability to assume initial, continuing, and final responsibility. The nurse should have at least two years of broad cultural education beyond the level of high school, followed by a professional education. Who shall organize and direct nursing education? It seems obvious that the university or some other institution of higher learning should organize, direct, and control nursing education.

Practices in our schools of nursing: Miss Blanche Pfefferkorn provided some interesting information. In 1943, 81 per cent of the schools of nursing required 18 years or over as an admission age for students. In 1946, 55 per cent required 18 or over, 28 per cent 17 to 18, 17 per cent less than 17. In 1932, 78 per cent of the schools of nursing granted allowances; in 1946 only 14 per cent granted allowances.

Understanding of the curriculum: At this interesting round table the opening speaker stated that many of our difficulties in schools of nursing are due to a lack of understanding of the curriculum on the part of many who contribute to the program of the school of nursing. She stated the following problems as examples:

1. The emphasis that head nurses and doctors place on service as opposed to education as evidenced by their opposition to the amount of time that the student "wastes" in the classroom and in classes held on the ward.

2. Doctors who come late for their lectures, sometimes as much as half an hour late!

3. Poor experience assignments to student nurses, assignments being based on service needs rather than on the learning needs of the student.

4. Requests from agencies providing affiliated programs that students come better prepared for this experience in order that they may more quickly fit into the service.

5. Students carrying too many non-nursing and non-learning activities.

6. Inadequate facilities provided for teaching.

7. The criticism that nurses are being educated away from the bedside.

The following suggestions for improving the understanding of the curriculum and so improve the education of the student were made: The director of the school should have a democratic program. To establish good rapport requires careful planning for meetings. It is a good idea sometimes to have members of the board and/or the school of nursing committee attend faculty meetings, not specially selected meetings where everything goes well. It does no harm for members of the board to appreciate some of the difficulties. Select articles appearing in the professional journals and give them to members of the school of nursing committee to read, and follow this up with a discussion of the article. The personnel of the school of nursing committee should include leaders from the field of general education. Promote better understanding among the physicians by soliciting their participation in the teaching program; getting their participation on nursing committees; learning how to supply good and sufficient nursing service by effective utilization of auxiliary workers. The students themselves should have a careful orientation to the school and to each new operation of the program; participation on faculty committees in reference to the school; student and faculty-student organizations.

Guidance program in the school of nursing: Miss Phoebe Gordon, of the University of

Minnesota, stated that faculty interest and participation is very essential in a guidance program. A trained counsellor is not necessary but is desirable. Guidance is an important part of every teacher's responsibility.

Health statistics: The speaker who introduced this topic made the statement that the term "Vital Statistics" is obsolete, that "Health Statistics" is to be preferred. It was pointed out that the nurse must be able to see her work in relation to the community, that it is extremely difficult, if not impossible, to separate health from social statistics and that, therefore, it seems logical to incorporate into the basic curriculum a modification of the statistical course that is now included in most post-graduate public health nursing courses. The need for adequate preparation of the faculty as a whole was emphasized since all members would have an opportunity to contribute in some way and at some time to this phase of the student program.

Advanced courses in special fields of nursing: Out of the panel discussion on this topic the following are some of the points which were made: Any nurse should have advanced experience and preparation in the field in which she proposes to teach or supervise. We have been imposing the principles of teaching and supervision on an inadequate basis. Our present aim should be to develop the opportunity for further preparation and advancement in qualification that does not mean further removal from the patient.

Notes du Secrétariat de l'A.I.C.

POLITIQUE DE L'A.I.C. CONCERNANT LA DISTINCTION DE RACE

Par la voix des journaux, l'attention de l'Association des Infirmières du Canada a été attirée sur une enquête menée par le conseil national du "Young Women's Christian Association" à savoir: "Si, dans les écoles d'infirmières, l'on faisait une distinction entre les races." Le résultat de cette enquête fut publié dans plusieurs journaux du Canada. Il semble sage et nécessaire de faire connaître à toutes les infirmières, de même qu'au public, la politique de l'A.I.C. à ce sujet, qui est le suivante:

L'Association des Infirmières du Canada, lors de son assemblée générale en juin, 1944, a, une fois de plus, réaffirmé sa politique concernant la distinction de race par la résolution que voici:

Comme il a été porté à l'attention du conseil exécutif de l'A.I.C. que les distinctions de races étaient faites dans certaines écoles d'infirmières du Canada, il a donc été résolu que l'A.I.C., à son 22e congrès biennal tenu à Winnipeg en 1944, réaffirma sa politique supportant le principe qu'aucune distinction de race soit faite dans le choix des étudiantes désirant s'inscrire dans une école d'infirmières.

Cette résolution fut adoptée à l'unanimité.

RENSEIGNEMENTS REÇUS

Durant ces derniers mois, l'on a fait circuler plusieurs questionnaires dans les écoles d'infirmières du Canada dans le but d'obtenir des renseignements précis.

Ces renseignements étaient demandés par le Ministère National de la Santé et du Bien-Etre au sujet du personnel hospitalier au Canada sur le nombre maximum d'infirmières pouvant être formées dans nos écoles. La possibilité de former des aides est aussi étudiée.

Un autre questionnaire avait pour but d'obtenir un tableau réel de la pénurie d'infirmières en service général, hospitalières (head nurse), surveillantes et institutrices dans nos écoles d'infirmières et dans nos hôpitaux y compris les sanatoria et hôpitaux pour maladies mentales.

Le troisième questionnaire avait pour but d'étudier le nombre d'infirmières quittant nos écoles et la cause de ces départs. Comme d'autres rapports seront demandés plus tard et afin de pouvoir faire la comparaison entre eux, on a demandé aux directrices des écoles de continuer à noter ces renseignements.

Lorsque l'élève quitte l'école pour plusieurs raisons, la plus importante cause doit être notée.

Afin de faciliter l'étude de ce problème, les causes de départ énumérées ci-dessus sont à la base du problème étudié par les infirmières: (1) Ne réussit pas en classe. (2) Ne réussit pas dans son travail pratique. (3) Ne peut suivre le règlement, ni se tenir à la hauteur de l'école. (4) N'a pas la maturité voulue. (5) Mauvaise santé. (6) N'a ni

la personnalité, ni le tempérament convenant à une infirmière. (7) Déception concernant le cours d'infirmière. (8) Déteste le soin des malades. (9) Doit se marier. (10) Raisons personnelles: (a) difficultés familiales; (b) mortalité dans la famille; (c) ennuie; (d) grossesse; (e) embarras pécuniaires; (f) études supérieures.

ASSEMBLÉE ANNUELLE DE LA "NATIONAL LEAGUE OF NURSING EDUCATION"

La "National League of Nursing Education" a tenu sa 51e assemblée annuelle à Seattle, Wash., du 8 au 11 septembre 1947.

Mlle É. Mallory, de Vancouver, 2e vice-présidente de l'A.I.C., fut notre représentante. Mlle Mallory aidée de Mlle A. Wright, secrétaire de l'Association des Infirmières de la Colombie-Britannique, a préparé un intéressant et encourageant rapport sur ce congrès, qui sera présenté au conseil de l'A.I.C. Le manque d'espace ne nous permet pas de publier ce rapport en entier, mais voici quelques-uns des principaux faits:

Le fait d'assister à une assemblée où se trouvent réunis les maîtres de l'éducation en nursing aux Etats-Unis et de les entendre discuter de leurs problèmes fut pour moi une expérience très encourageante et très intéressante.

En revenant j'ai fait les réflexions suivantes:

Que j'avais assisté à des conférences préparées dans le but de répondre absolument à mes propres besoins; que notre façon de penser au Canada et aux Etats-Unis est souvent analogue; que les infirmières canadiennes ont de grandes dettes envers la National League; depuis des années nous nous sommes servies de leurs études et probablement que nous continuerons à le faire; ces études sont modifiées de façon à convenir à nos besoins, mais les idées, à la base, restent très souvent celles mêmes de la National League.

Je me demande parfois si nous ne pourrions pas, pour notre propre compte, faire un plus grand effort, si nous n'avions pas à la portée de la main, une source de renseignements de si grande valeur. Je reviens au pays, convaincue qu'au Canada, nous n'avons aucune organisation pouvant se comparer à la "National League of Nursing Education" et pourtant nous en avons grandement besoin.

Très peu de temps fut alloué à la lecture des rapports ordinaires. A la séance d'ouverture, le lundi matin, les rapports des officiers, des convocatrices des comités, etc., furent acceptés tels que présentés dans le livret remis à chacune des infirmières inscrites. Ce procédé facilita l'adoption des rapports mais ne favorisa pas la discussion. Ces rapports ne pouvant être obtenus que le dimanche, lors de l'enregistrement, l'on peut penser que très peu étaient au courant du contenu.

Programme: Tout le programme était résumé sous ce titre général: La formation de l'infirmière en relation des besoins du public.

La matière fut présentée au moyen de discussion par groupe, conférences intimes, symposium, et par des conférenciers qui parlèrent de sujets qui leur étaient très familiers.

Relations extérieures: Les relations extérieures, qui se sont d'abord développées dans le monde des affaires, s'étendent maintenant pratiquement à toutes les autres activités, fit remarquer Monsieur B. Christian.

Le terme "relations extérieures" a bien des sens tel que: Bien s'entendre avec les gens; avoir de la valeur et de se faire apprécier en raison de cette valeur; mettre 90 pour cent de son application à faire un bon travail et 10 pour cent à en parler. C'est encore faire connaître un programme préparé, une politique et une conduite qui gagnera la confiance du public et augmentera sa compréhension. Le but doit être de se faire des amis (pour l'organisation ou pour la cause) permanents.

La préparation d'un programme est chose essentielle, mais la préparation de la politique qui déterminera la conduite à tenir est de la plus grande importance. Ce dont nous avons besoin, ce ne sont pas des propagandistes, mais des personnes susceptibles de renseigner sincèrement le public sur ce que nous avons à lui offrir.

Les participants insistèrent, lors du symposium qui suivit cet énoncé, sur les relations extérieures dans l'école d'infirmières que l'on peut comparer a un chemin double partant d'un point et y revenant, à savoir: L'école a besoin de meilleures relations extérieures pour recruter des candidates désirables et il est du pouvoir de l'école d'infirmières de produire des infirmières diplômées dont la réputation et la qualité feraient la vente. En d'autres termes, la valeur des diplômes fait la réputation de l'école.

Le recrutement de l'élève infirmière: Un des conférenciers affirma qu'aujourd'hui une femme pouvait choisir entre 20,000 positions et que les écoles d'infirmières entrent en lutte avec bien d'autres professions pour leur recrutement parmi les 10 pour cent des élèves finissant leur école élémentaire supérieure.

Il se peut que les infirmières insistent trop sur la spécialisation et pensent plus à demain qu'à aujourd'hui et du fait négligent le besoin général des soins aux malades, besoin qui se fait sentir actuellement dans les hôpitaux.

Cette conférencière demanda que l'on insiste davantage sur l'idée de servir. Cet appel de "servir" sourit aux jeunes filles. Un autre conférencier recommanda de ne rien charger pour l'enseignement, mais au contraire de donner une rémunération. L'Association des Hôpitaux américains demanda d'éliminer toutes restrictions concernant l'âge.

L'éducation de l'infirmière en rapport à l'éducation générale: Le Dr E. Johnson, de l'Université d'Oregon, dit que nous devions nous demander quelles relations doivent exister entre l'éducation libérale (qui exige surtout l'intervention de l'intelligence) et l'éducation professionnelle (formation technique). Quels sont les facteurs nécessaires pour atteindre un juste milieu entre les deux? Les sciences sociales et les humanités devraient occuper beaucoup plus de place dans le cours de l'infirmière. Nous avons besoin d'être éduqué pour la vie et non seulement d'être éduqué pour gagner sa vie.

Mlle M. Tracy, doyen de l'Université de Californie, dit notre préoccupation la plus importante est de donner une meilleure formation à l'infirmière et notre plus grand problème est de trouver les moyens pour atteindre à ce but. Elle mentionne la grande différence existant entre le nombre de lits dans les hôpitaux ayant une école d'infirmières. Savons-nous lequel de ces hôpitaux peut donner la meilleure formation à l'infirmière?

Quel nombre d'étudiantes aurons-nous lorsque nous donnerons la meilleure préparation? Au point de vue de la formation de l'infirmière, est-il plus économique à un hôpital d'un certain nombre de lits plutôt qu'à un autre d'avoir une école?

Un travail de recherche pourrait peut-être nous aider, demanda Mlle Tracy. Le mot "recherche" est un grand mot qui effraie bien des gens. Ce mot veut dire sortir de son habitude pour faire des changements, au lieu d'attendre que les changements parviennent jusqu'à nous.

Le rapport du Dr E. Lucille Brown sur le travail accompli à date sur l'étude des écoles d'infirmières fut le clou du congrès.

Les observations du Dr Brown dans les hôpitaux l'ont amenée à faire certaines conclusions tel que: (1) Les hôpitaux ont besoin d'un personnel terriblement nombreux. (2) Dans les hôpitaux, il se fait beaucoup de recherches (chez le malade), dépistage, recherche des causes de la maladie, analyses, rayon X, etc. (Pour les médecins) l'expérience de traitements, compilations de cas, etc.

Et ce travail devient de plus en plus complexe, il s'en suit que le médecin confie beaucoup de ses responsabilités à l'infirmière. L'infirmière assume la responsabilité des patients atteint de maladies aiguës. L'on dépense une fortune à la guérison des maladies et il s'en suit que l'on manque de fonds pour développer une médecine préventive. Les infirmières ne devraient pas gaspiller leur énergie à des devoirs qui pourraient tout aussi bien être remplie par des aides.

Le Dr Brown dit que si l'on considère le travail et la responsabilité de l'infirmière professionnelle, il est évident que l'instruction qu'elle reçoit dans un cours primaire supérieur n'est pas suffisante. Elle doit être capable d'assumer une responsabilité continuelle, souvent en prendre l'initiative et la continuer au besoin et savoir quand la terminer.

L'infirmière devrait avoir, en plus de son cours primaire supérieur, deux années de culture générale qui seraient suivies du cours professionnel.

Qui doit organiser et diriger l'éducation de l'infirmière? Il semble évident que les universités ou autres institutions d'éducation soient chargées de l'organisation, de la direction et du contrôle de l'instruction de l'infirmière.

Pratiques courantes dans nos écoles d'infirmières: Mlle Blanche Pfefferkorn nous donna des renseignements intéressants sur quelques pratiques courantes dans nos écoles. En 1943, dans 81 pour cent de nos écoles l'on exigeait que les candidates admises aux écoles soient âgées de 18 ans. En 1946, 55 pour cent de nos écoles exigent qu'elles soient âgées de 18 ans ou plus, 28 pour cent de 17 à 18 ans, et 17 pour cent moins de 17 ans. En 1932, 78 pour cent de nos écoles donnaient une rémunération aux élèves. En 1946, ce nombre est tombé à 14 pour cent.

La compréhension du programme d'étude: Bien des difficultés dans nos écoles d'infirmières résultent d'un manque de compréhension de la part de personnes prenant part à la réalisation du programme d'étude, par exemple:

1. Trop souvent les médecins et les hos-

pitalières parlent avec trop d'insistance du temps que les élèves perdent en classe et durant l'enseignement clinique au lieu d'être au service des malades.

2. Les médecins qui arrivent en retard aux cours, des fois même jusqu'à une demi-heure de retard.

3. L'expérience pratique des élèves est souvent négligée; les élèves sont souvent envoyées dans les services non pour ce qu'elles ont besoin d'apprendre mais pour répondre aux besoins de l'hôpital.

4. L'on apprécie par les possibilités d'affiliation avec d'autres institutions, ce qui permettrait aux élèves d'être mieux préparées une fois sortie de l'école.

5. Les élèves font trop de choses non professionnelles et des choses qui ne leur apprennent rien.

6. Les conditions ne sont pas favorables à l'enseignement.

7. Les critiques qui se font que la formation de l'infirmière se fait loin du lit du malade.

Voici quelques suggestions de nature à favoriser la compréhension du curriculum et ainsi améliorer l'enseignement chez les élèves. La directrice de l'école doit avoir un programme démocratique. Pour qu'il y ait entente entre les divers membres chargés de l'exécution du programme (théorie et pratique) des assemblées régulières doivent être préparées avec soin.

C'est une idée que d'admettre quelques fois des membres du bureau de direction et du comité des écoles à ces assemblées, non pas à des assemblées spécialement choisies où l'on sait que tout ira bien. Cà ne fait pas de tort que les directeurs se rendent compte de quelques-unes de nos difficultés.

Choisissez des articles paraissant dans les revues professionnelles et donnez les à lire aux membres du comité de votre école, après ayez une discussion sur cet article. Parmi le personnel du comité des écoles, il doit y avoir un éducateur renommé.

Favorisez la bonne entente avec les médecins en leur demandant de participer à l'enseignement et ainsi les amener à faire partie du comité du nursing. Apprendre comment pouvoir donner suffisamment de soins aux malades en utilisant d'une façon adéquate les services des aides.

Les étudiantes mêmes devraient être mises au courant du travail qui se fait à l'école et de chaque nouvelle activité au programme.

Direction et orientation dans l'école d'infirmière: Mlle P. Gordon, de l'Université de Minnesota, dit que l'intérêt et la participation des membres de la faculté de l'école sont essentiels à l'exécution d'un programme d'orientation. Une personne spécialement préparée pour ce travail est conseillée mais n'est pas indispensable. La direction des élèves est une partie importante du travail de l'institutrice.

Cours supérieurs pour infirmières spécialisées: Ce sujet fut discuté par un groupe et voici quelques points discutés: Toute infirmière devant enseigner ou exercer une surveillance dans un des domaines du nursing devrait avoir une bonne expérience dans la matière et avoir reçu une préparation spéciale. Nous avons souvent demandé à des personnes d'appliquer les principes d'enseignement et de surveillance sans qu'elles aient la base nécessaire pour le faire. Actuellement notre but devrait être de favoriser la préparation et l'avancement de ces personnes tout en les gardant au chevet du malade.

Ice as a Local Anesthetic

For home use, or emergencies, or when the area is badly infected and an injection of novocaine is unwise, or where ethyl chloride causes too much pain because of its burning sensations, ice is the method of choice for anesthesia.

I have found ice to be useful in the following types of cases:

Infected toenails: Keep ice in sterile gauze to a previously sterilized skin for 20 minutes.

Carbuncle or boil: Ice works best in these cases; keep ice on area for 20 minutes.

Paronychia: Keep ice on for 10 minutes.

Dislocations of wrists, fingers, and elbow: Keep ice on area with a little pressure, for 20 to 30 minutes.

Abscesses anywhere on or near the skin surface: Keep ice on area between 15 and 20 minutes.

Skin growths (nevi and the like): Keep ice on areas for 10 minutes and remove growth by knife or cautery.

—Halley H. Friederwitzer, M.D., in *Medical Record, January, 1944*

Nursing Profiles

Eugenie Margaret Stuart has joined the staff of the McGill School for Graduate Nurses in the capacity of assistant professor in school of nursing administration.

Miss Stuart has had a broad background of administrative experience and training as a preparation for her new work. Graduating from the Toronto General Hospital in 1925, she shortly became a head nurse in the surgical department there. In 1928 she enrolled in the certificate course in hospital administration and teaching at the University of Toronto School of Nursing. For the next five years she served as surgical supervisor and science instructor at T.G.H., joining the University of Toronto faculty as a clinical instructor in 1934.

The lure of distant fields called and in 1938 Miss Stuart joined the staff of Groote Schuur Hospital in Cape Town, South Africa, going to the General Hospital in Kimberley, S.A., the following year as sister tutor. She returned to Canada in 1940 to become superintendent of the Oshawa General Hospital. Last year, Miss Stuart further enriched her background when she obtained her B.S. degree in hospital administration at Northwestern University, Chicago, the first Canadian nurse to secure this standing. Her appointment to the McGill School strengthens the splendid opportunities available to nurses there.

Howard Smith, Chicago

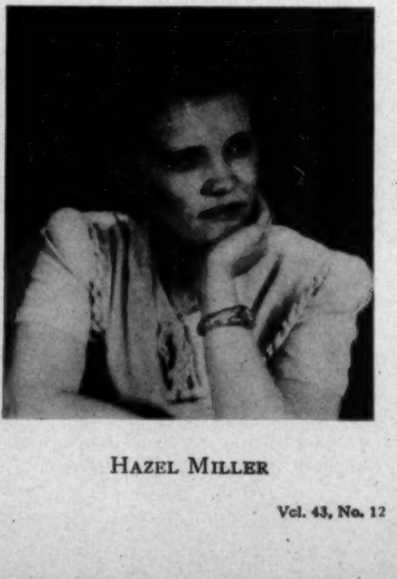
Eugenie Stuart

The announcement was made recently of the appointment of **Hazel Miller** to the National Office staff of the Victorian Order of Nurses for Canada as travelling supervisor. After graduating from the Winnipeg General Hospital in 1934, Miss Miller engaged in private duty nursing and in addition had short periods of experience with the Winnipeg Branch of the Victorian Order of Nurses, the Metropolitan Life Insurance Company, and in the industrial field. In 1945, she attended Columbia University and obtained a B.S. degree in public health nursing, at which time she received valuable experience in supervision, followed by a period of staff duty with the Visiting Nurse Service of New York (formerly Henry St.).

Since obtaining her degree Miss Miller has been with the Winnipeg City Health Department, first as staff nurse then as tuberculosis consultant and more recently as district supervisor in the generalized public health nursing program. She has played an active part in professional affairs and was convener of the Public Health Section of the Manitoba Association of Registered Nurses, 1945-46.

Miss Miller is well qualified for her new responsibilities and the National Office staff look forward to their association with her.

Marjorie Gordon Russell, A.R.R.C., who was matron-in-chief of the nursing



Hazel Miller

service of the Royal Canadian Navy during World War II, retiring with the rank of commander, has assumed new duties as director of nursing at the Homoeopathic Hospital, Montreal. Born in Dhar, India, of Scottish and Welsh parentage, Miss Russell received her high school education in Northern Ireland. In 1923 she graduated from the Hospital for Sick Children, Toronto. She was in charge of the pediatric department at the Montreal General Hospital for three years, later returning to the Hospital for Sick Children where she was in charge of the Private Patients Department until her enlistment in 1941

Marion E. (Paterson) Botsford is the new assistant registrar with the Registered Nurses' Association of B.C. Born and educated in Manitoba, Mrs. Botsford graduated as a Bachelor of Arts from the University of Manitoba in 1927. She enrolled in the school of nursing at the Royal Victoria Hospital, Montreal, completing her training in 1930. The following year she received her certificate in teaching and supervision at the McGill School for Graduate Nurses. Public health nursing, private duty, and general staff duty at Deer Lodge Hospital, Winnipeg, preceded her marriage in 1937. In 1941, Mrs. Botsford returned to nursing as assistant executive secretary and later acting registrar of the Manitoba Association of Registered Nurses. Friends, golf, and books mean much to the new assistant registrar.

Bernice Charlotte Underhill has been appointed matron of the King Edward VII Memorial Hospital, Bermuda. A native of New Brunswick, Miss Underhill had three years of public school teaching experience before she entered the school of nursing of the Montreal General Hospital. She remained there in various positions after graduating in 1932. Receiving a scholarship from M.G.H. in 1934, she enrolled for the certificate course in teaching and supervision at the McGill School for Graduate Nurses, then joined the school of nursing office staff of the Vancouver General Hospital. A year later she returned to M.G.H. going to Bermuda in the autumn of 1937. She joined the staff of King Edward VII Memorial Hospital in 1938 as instructor, becoming assistant matron in 1942. In March of this year, Miss Underhill completed a course in clinical teaching at Vanderbilt University, Nashville, Tenn., on a scholarship received from Lady Hall of Bermuda. Miss Underhill is fond of reading and music, is interested in travel and languages, and loves her game of golf.

John S. Steele

MARJORIE RUSSELL

Katherine Barr is assistant director, responsible for the educational program, with the Nursing Division of the City of Winnipeg Health Department. Miss Barr was born and educated in Winnipeg. She holds the

Walden S. Fabry

BERNICE UNDERHILL

ELLEN WICKLUND

degree of Bachelor of Arts conferred by the University of Manitoba and also the collegiate teaching certificate granted by the Provincial Normal School. Prior to entering the school of nursing of the Winnipeg General Hospital in 1939, she was engaged for seven years as teacher in the public schools of Manitoba. Upon graduation, she entered the public health field, devoting the greater part of her time and effort to the child guidance and mental hygiene programs. The recipient of a generous scholarship from The Commonwealth Fund, Miss Barr spent a year at Columbia University, New York, where she received her Master's Degree in nursing education.

An honor, unique in nursing annals, was conferred upon **Ellen C. Wicklund** when she was named "Good Citizen" for Maple Ridge, B.C., by unanimous choice. A nurse for thirty years, Miss Wicklund started her career of service when she entered St. Barnabas Hospital, Minneapolis, in 1915. Many of her active years were spent in Saskatchewan. She settled in Maple Ridge fifteen years ago, answering the calls of illness in the homes throughout her community, the nearest hospital being many miles distant. Miss Wicklund is a keen gardener and lover of flowers, and spends as much time as possible between calls at this work she loves.

A very interesting experience is in store for **Beulah Evelyn Holt** and **Gwyneth Goldsmith Jones.** They have exchanged their positions for this year, Miss Holt going to the Vancouver Metropolitan Health Service and Miss Jones to the Elgin-St. Thomas Health Unit in Ontario. Miss Holt graduated from Victoria Hospital, London, Ont., in 1943, receiving her certificate in public health nursing from the University of Western Ontario, London, the following year. Miss Jones is a graduate from St. Paul's Hospital, Vancouver, with the class of 1938. She took a post-graduate clinical course at the Hospital for Sick Children, London, Eng., and in 1943 obtained her certificate in public health nursing at the University of British Columbia. Miss Holt enjoys music, poetry, and tinting photographs as her leisure-time activities while Miss Jones specializes in sports including badminton, riding, hiking, and skiing.

Hilda Muir Stuart, who since 1931 has been principal of the school of nursing of Victoria Hospital, London, where she graduated in 1913, has retired. During World War I, Miss Stuart served with the British Red Cross in Cairo, later joining the Q.A.I. M.N.S. for service in France then returning to Canada with the C.A.M.C. She is the proud possessor of the Mons Medal, the General Service Medal, the Victory Medal, and King George V Silver Jubilee Medal.

Miss Stuart has served as secretary-treasurer and chairman of District 1, R.N.A.O. She held membership in the Isabel Hampton Chapter of the I.O.D.E., all the members of which were graduate nurses. Miss Stuart's sphere of usefulness now includes the tasks of liaison officer between the hospital and its graduates. This is a recognition of her long record of faithful service and enables the Victoria Hospital to continue to make use of her unparalleled knowledge of the graduates.

Agnes Young Sutherland, who graduated from Royal Victoria Hospital, Montreal, in 1916 and who has been night superintendent there for more than two decades, has retired. Years ago, Miss Sutherland's initials were paraphrased in the school year book as "At your Service." Her unfailing interest in the welfare of the patients and her friendly guidance of the students under her direction have proven the validity of this phrase. She has decided to live in Brandon where she can have a garden and indulge her heart's desire to keep house and bake goodies. Miss Sutherland was presented, among other gifts, with a record-player on which she can satisfy her love for good music.

Ideals are like stars — we never reach them, but like the mariner on the sea, we chart our course by them.
—CARL SCHURZ

Dos and Don'ts in Nutrition

Dr. I. Rabinovitch, noted biochemist, who is director of the Institute for Special Research and Cell Metabolism in the Montreal General Hospital, and associate professor of medicine, McGill University, would like to see certain rules in cook books, and outlined the following "Dos and Don'ts" for housewives:

When buying apples, get small ones; the vitamins are concentrated just below the skin, and one pound of small apples contains more of the vitamins than a pound of large apples.

When purchasing leafy vegetables, select the thin leaf—pound for pound it contains more vitamins than the thick leaf.

Whenever possible buy only the day's needs—between gathering and serving, fresh vegetables lose as much as 50 per cent of their vitamin value.

Handle leafy vegetables carefully, because bruising of the leaves causes loss in vitamin value.

Dried green peas increase in vitamin value with the length of time they are soaked. If soaked for three or four days they have a higher vitamin content than even grapefruit.

Do not use baking soda to preserve the fresh green color of vegetables. The nutritional value is not in the color, and the ordinary heating with baking soda destroys vitamin C completely.

Potatoes boiled in their jackets are more nutritious than the peeled variety. Scraping potatoes wastes 5 per cent, peeling them wastes 20 per cent of the vitamin values.

Do not put vegetables in boiling water all at once. Shred them and put into the water a little at a time, without letting the water go off the boil.

Olive oil differs from vegetable oils from other sources in flavor only. It is in no way superior from a nutritional point of view.

Think in terms of the satisfying value of foods. Hunger may at times merely be due to an empty stomach and not to insufficient calories. Foods that remain longest in the stomach have the most satisfying value—bread and butter, bread and gravy, or hard-boiled eggs.

—*Health News*

In Memoriam

Carrie E. (Coleman) Bath, who was director of nurses for many years at St. Luke's Hospital, New York, died on September 13, 1947, in Paris, Ont., where she had resided since her retirement from nursing twenty-five years ago. Born in Grafton, N.S., Mrs. Bath trained at St. Luke's Hospital. Last year a scholarship named in her honor, "The Carrie E. Bath Scholarship," was awarded at St. Luke's for the first time.

Jessie Bell, who graduated in 1919 from the Galt (Ont.) General Hospital, died recently. Until a few weeks prior to her death, Miss Bell had served as a very active and faithful private duty nurse.

Alverna Debonardi, aged twenty-seven, a graduate of St. Joseph's Hospital, Chatham, Ont., died on September 30, 1947, from injuries received in an automobile accident. Miss Debonardi had worked at St. Joseph's Hospital following graduation.

Mrs. A. W. (Hunter) Eltherington, who graduated in nursing in Regina in 1917, died at her home in Preston, Ont., on October 5, 1947.

Hannah J. (Cody) Grant, who was a member of the second graduating class of the Toronto General Hospital in 1884, died at her home in Toronto on September 27, 1947, at the advanced age of ninety-two years. Mrs. Grant was the first superintendent and director of nursing of the Hospital for Sick Children, Toronto, serving from 1886 to 1891. In 1893, she married the late Rev. Dr. James Grant, a Baptist minister, who died in 1914.

Yvette Laporte, aged thirty, who graduated from Hotel-Dieu, Montreal, in 1943, died on September 19, 1947, from leukemia. Miss Laporte had refused to stop work despite her illness, winning for herself unstinting tribute.

Mrs. Hugh (Bell) Parks, a graduate in 1919 of Victoria Hospital, Prince Albert, Sask., died recently.

STUDENT NURSES PAGE

Frost-Bite

Lois Riddell

Student Nurse, St. Elizabeth's School of Nursing, Sudbury, Ont.

Cause: "The temperature in downtown Sudbury is 20° below zero," coolly says the voice of your favorite radio announcer. You adjust your scarf, pull up your collar, tighten your ear-muffs, and sally forth, undaunted by King Winter's attempt to bend you to his will. But you have not gone far when you wish that you were sunning yourself on Florida's sands, or skimming through space in a sleek airliner to some obscure tropical isle.

Even in the air Jack Frost may besiege you. During the last war, it was found that impatient air gunners, removing their gloves to "strip a gun" more conveniently, found to their surprise their fingers waxy white and solid as a rock. The damp wet fog of London is also an ally of King Winter. In the air-raid shelters, numerous cases of frost-bitten feet were reported at normal temperatures from 50° to 70°F. This demonstrated that winter robs body tissue of precious heat quickly.

Wind also plays havoc with tissue heat, and frost-bite occurs more easily when there is a wind present. The three causes of frost-bite then are: cold air, water, wind.

Physiology: The physiology of Jack Frost's disabling attacks on tissue is that there is a slow lessening of the flow of blood to the affected area because constriction of the tiny blood vessels occurs, until circulation ceases altogether. When the victim returns to a warm place, the circulation remains blocked for an hour or more, then it returns in a veritable flood. This congestion lasts from 16 to 18 hours. If the circulation ceases once again, necrosis sets in. During the stage of inflammation, tissue damage occurs. The small blood capillaries, damaged by the cold, break under the increased pressure of blood, and plasma leaks out, causing blockage, of circulation, and tissue necrosis develops from lack of oxygen. Interesting discoveries leading to the explosion of ideas regarding treatment have been developed recently:

1. The age-old method of friction with snow was one of the first to be vetoed. Remember when grandma engulfed you in blankets, seated you near the stove, and brisky rubbed your frost-bitten ear or nose or toes with snow? Medical practitioners today frown upon this, on the theories that (a) the proximity of the stove and the friction of the snow cause heat. Heat brings a rush of blood to the constricted blood vessels, causing tissue damage; (b) water causes more tissue damage; (c) cold (snow) causes more tissue injury.

2. In a series of experiments with frogs, it was shown that frozen tissues are not brittle, and will not break off like an icicle.

3. It is the thawing out, not the solidification of tissues, that causes harm.

Treatment: The first step in treatment, of course, is prevention. This includes warmer clothing; precaution against wet clothing; intensive teaching of the dangers of cold wind; cupping a gloved hand over a nipped ear to keep in body heat.

The treatment when frost-bite is resolved has taken a definite change. As soon as the patient is brought indoors, the limb is elevated to lessen circulation to the restricted areas. An electric fan is the ideal method of keeping the limb cool and slow thawing is the essential method of treatment. If the fan is unavailable, ice bags may be used. Rolls of cellucotton may be placed around them to act as a thermos. This treatment lasts from six to seven days. On no account should moist dressings be placed on the limb, as this only furthers tissue damage.

If the hands or feet are frozen, pledgets of absorbent cotton or gauze should be placed between the fingers and toes to prevent the skin from sticking. The frozen parts should be gently supported with "doughnut" pillows and absorbent, so that the injured limb is spared as much pressure as possible.

The serum in the blood being forced into the tissues promotes clumping of the red cells, which may result in gangrene. To offset this, the use of a new anti-coagulant has been found beneficial. Heparin and Dicumarol have been found remarkably successful in this instance.

The patient may also suffer from upper respiratory infections which are treated by penicillin and the sulpha compounds.

Fluids are given freely, and a sedative anti-spasmatic is usually ordered for the pain. These measures offset shock that may develop and help to combat spasm of the affected blood vessels.

In cases of frost-bite with tissue necrosis, amputation is inevitable. The space left may be repaired by skin grafts, or application of red blood cells may promote healing without grafts. Thermolite treatment usually follows both methods. Vitamin C is given also to promote tissue growth.

Modern science has caught Jack Frost napping, and found out his secrets at last. Don't let Jack Frost catch you napping! Dress warmly—wear your rubbers when it's raining. Whatever you do, don't stand still too long in below-zero weather.

Book Reviews

The Infant and Child in Health and Disease, with Special Reference to Nursing Care, by John Zahorsky, M.D. and Elizabeth Noyes, R.N. 496 pages. Published by The C. V. Mosby Co., St. Louis. Canadian agents: McAinsh & Co. Ltd., 388 Yonge St., Toronto 1. 2nd Ed. 1946. Illustrated. Price $3.50.

Reviewed by Mrs. Edgeworth Burry, formerly Nurse in Charge, Children's Department, Royal Alexandra Hospital, Edmonton.

This tremendous subject has been covered in this, the second edition, by excellent judgment in the form of its presentation and omissions. Experience, commonsense, and simplicity are found in all the chapters.

The short paragraph on Discipline is food for thought as well as an appetizer. Nurses and parents need a great deal of help in this field. Chapter 2, Practical Hygiene, is very satisfying in the systematic handling of daily routine care of the infant. The mother's diet is discussed adequately and sensibly, as is the feeding of the infant and child which is of paramount importance for the well-being of both.

The interpretation of infants' stools is usually a stumbling-block for all but those with considerable experience. There are three excellent color plates on this subject.

The pediatric nurse requires knowledge of the common household poisons and hazards. In Part II, the treatment in emergencies of poisons and minor accidents has been included. This is frequently overlooked in pediatric textbooks, though it is very often encountered in hospital and home life.

This book is practical in the listing and summing up of the diseases of infants and children with good illustrations and color plates. It is a very valuable book for all those who are seeking knowledge in the care of the well and the ill child. The authors have put countless hours of work and experience into a very presentable form.

Legal Aspects of Nursing, by Milton J. Lesnik and Bernice E. Anderson, R.N. 352 pages. Published by J. B. Lippincott Co., Medical Arts Bldg., Montreal 25. 1947. Price $4.50.

Reviewed by James and Florence Wilson of Winnipeg, Man.

Most nurses, in common with other average non-lawyers, have only a very hazy notion of what the law and being a lawyer involves; to return the compliment, it may be said with confidence that very few lawyers have any idea at all of the daily routine of nursing, beyond the fact that it often involves changing dressings and preparing very neat but rather obscure charts. Nurses would recoil in horror from the suggestion that, even in thirty hours of study, the average lawyer could from a single volume obtain a clear insight into the duties and responsibilities of the professional nurse. Albeit, the authors of "Legal Aspects of Nursing" assume the ambitious task of providing for nurses a statement of the view taken by the law of almost every phase of their work.

On the whole, however, this onerous task is quite well done. "Legal Aspects of Nursing," written by a lawyer and a nurse, has been written "to state fundamentals of law which either explain the reasons underlying the manner in which activities of nursing or those closely identified with nursing are rendered or the consequences of failure to do so."

The first three chapters deal with the evolution of nursing and its legal control, the next three discuss the law of contracts, the seventh and eighth chapters are on the legal aspects of negligence and other torts, the ninth chapter deals briefly with crime, the tenth with wills, and the final chapter with formation of governments, courts, and legal procedure and trial.

We all know that the laws of one country are not the same as those of another and, therefore, in reviewing for Canadian nurses a book written by Americans, for American nurses, the prime factor one must consider is — Are the laws of the two countries similar enough to make "Legal Aspects of Nursing" helpful to Canadian nurses? It will be obvious that the first chapters discussing registration of nurses and steps leading to it in the U.S.A., and the last chapter on formation of American governments and courts, although of interest to the Canadian nurse, depict the American scene only and, therefore, will not be particularly helpful to the Canadian nurse.

The remaining chapters, however, on contracts, negligence, assault and battery, slander and libel, crimes, and wills, which constitute the greater part of the book, should make interesting and worthwhile reading for the Canadian nurse, since there is enough parallel between the laws of the two countries on these topics. The discussion of contracts should be mentioned as being of particular value—what a contract is, who may make a contract, breach of contract, and so on — because nurses are continually entering into contracts.

Negligence is obviously of grave importance to all nurses and the authors caution: "The penalty for acting negligently may be greater than anticipated. The natural consequences which may flow from an initial act of negligence are limitless. Responsibility may ensue for all." This subject is treated in detail. Of particular note, on page 148 in a section entitled Nursing and Negligence (Malpractice), we find an extremely comprehensive definition of that difficult-to-define subject — nursing.

The book is liberally sprinkled with examples drawn from nursing situations, and although one occasionally feels that the examples are highly improbable—e.g., page 183 illustrating an assault — they do make the point more understandable.

On page ix of the preface the authors give it as their opinion that legal aspects of nursing should constitute a separate topic in the basic nursing course, and time-tables are provided to suggest how the contents of the book might be covered, in either thirty or fifteen hours. It is difficult to see quite how a school of nursing would have this much time available. There are other aspects of nursing whose teaching would easily claim priority over law as it concerns the nurse. In any event, whether the book is simply treated as required reading, or is used as the basic text for a separate course, the reference or the opening lecture should very clearly point the moral drawn in the first paragraph of this review. And it is humbly suggested that for a nurse to offer "valuable comfort and advice" to an accident victim on the probabilities of his successfully sueing the other party (as the book says she may do on page 120) would be presumptuous.

However that may be, "Legal Aspects of Nursing" would certainly be beneficial reading for all Canadian nurses — perhaps a Canadian lawyer and a Canadian nurse will be inspired to produce a similar text.

The Practice of Mental Nursing, by May Houliston, R.G.N., R.M.N., R.F.N. 164 pages. Published by E. & S. Livingstone Ltd., Edinburgh. Canadian agents: The Macmillan Co. of Canada Ltd., 70 Bond St., Toronto 2. 1947. Price $1.75.

Reviewed by Barbara A. Beattie, Superintendent of Nurses, Provincial Mental Hospital, Ponoka, Alta.

This book is designed for the junior nurse to give guidance and understanding of the attitudes and techniques necessary for the care of the mentally ill. It also touches briefly on normal mental reactions of the individual and then proceeds to the abnormal behavior manifested in the disorders of the mind.

Miss Houliston stresses the qualities that must be developed in the successful psychiatric nurse stating that "there is no such thing as a born nurse" but that nursing "is an art and a discipline" which like all worthwhile things is "only learned by devotion and hard work."

Ward routine in mental hospitals is explained and precautions enumerated. Treatments used are also mentioned briefly, especially occupational therapy, recreational therapy, and psychotherapy. It also outlines the functions of a social worker in a mental hospital. The chapter on the history and development of mental hospitals is exceptionally well done.

While many of the terms vary somewhat from those used on this side of the Atlantic, taken as a whole it is a text that could be well recommended for elementary psychiatric nursing. Unfortunately, there are no illustrations used in the book, the addition of which might have given more "reader-appeal." The summary with which each chapter is ended is useful in the preparation of teaching material.

Le Soin des Malades, Principes et Techniques. Rédigé en collaboration par les Soeurs de la Charité (Soeurs grises) de Montréal. 814 pages. Distribué à l'Institut Marguerite d'Youville, Ecole supérieure d'infirmières (affiliée à l'Université de Montréal), 1185 rue St-Mathieu, Montréal 25. Illustré. Prix $6.50.

Revu par Soeur Jeanne Forest, directeur d'éducation, l'Hôpital Holy Cross, Calgary, Alta.

C'est avec beaucoup d'intérêt que j'ai étudié ce livre rédigé en collaboration par les Soeurs Grises de l'Hôpital Général de Montréal. Il sera certes bienvenu des étudiantes aussi bien que du personnel enseignant de nos écoles d'infirmières, les hospitalières qui exercent la surveillance dans les services, et toutes les infirmières diplômées, quel que soit d'ailleurs le champ de leur activité.

Le nursing, selon sa conception le plus moderne, y est considéré aussi bien comme prévention de la maladie par l'enseignement constant de l'hygiène que comme soin total du malade, soit à l'hôpital, soit à domicile, soit de jour ou de nuit. Le point de vue mental et religieux dirige tout le livre et celles qui le liront attentivement seront convaincues que pour bien remplir son rôle l'infirmière doit soigner "tout son malade."

Conformément au titre du livre, les principes servant de base à toute technique accompagnent chaque description et l'étudiante y trouve aussi les raisons, le pourquoi scientifique de chaque détail du traitement dans le but d'assurer le meilleur soin du malade. De nombreuses photographies, significatives et bien choisies, illustrent les différentes méthodes de traitement. Les techniques telles que décrites au cours du livre représentent les plus récentes améliorations dans le soin du malade et couvrent les nouveaux traitements et appareils aussi bien que les anciens. Les problèmes qui suivent chaque chapitre stimulent l'application pratique des théories énoncées et la liste des ouvrages à consulter est une auxiliaire bien précieuse pour quiconque veut élaborer le sujet étudié.

Ce livre est une mine de renseignements. Les auteurs méritent des félicitations et ont droit à la reconnaissance des infirmières canadiennes-françaises pour la composition de ce volume, fruit de nombreuses recherches, et le premier du genre publié dans leur langue.

Nurse-patient Relationships in Psychiatry, by Helena Willis Render, R.N. 346 pages. Published by McGraw-Hill Book Co. Inc., 330 West 42nd St., New York City 18. 1947. Price (in U.S.A.) $3.00.

Reviewed by Elva Cranna, Superintendent of Nurses, Brandon Mental Hospital, Man.

This is a book for nurses which, in the author's own words, "helps you realize your proper function in the field of psychiatry and to show inter-relationship with general nursing."

Nurse-patient relationships are clearly presented. In teaching student nurses the basic principles of nursing care, these relationships are fully as important as clinical skills. This book deals primarily with nursing care from the viewpoint of behavior and emphasizes the patient as a person. The meaning of behavior and the nurses' responsibility in observing, recording, understanding, and modifying is well presented. Useful lists of words describing general appearance and behavior are included. A discussion of the close relationship of emotional and physical health shows the importance of nursing the patient as a whole.

The objectives of psychiatric nursing are clearly defined and well illustrated. The principal objective is to modify moods and change attitudes and the achievement of this depends on the management of interpersonal relationships. A comparison of psychiatric and general nursing care brings out the similarity and shows that the only difference is in the shift in emphasis. The combination of their dominant aspects makes for perfection and completeness in each field.

Nursing care is discussed under the headings: Remedial Approach, Primary Personality Disorders, Special Problems, Rehabilitation and Secondary Personality Changes. A bibliography at the end of each chapter is especially helpful to the teacher. The chapter on rehabilitation outlines the group of workers involved and the specific way in which each group contributes to the rehabilitation program of the patient. The nurses' responsibilities, as related to each group, are clearly stated. Special points of the nursing care are discussed with emphasis according to treatment units.

The final chapter describes the use of art, literature, and music in the understanding of the patient's emotional states.

This book deals with the reality and philosophy of nursing rather than with techniques and routines. Because of this it is of great value to both the teacher and the student in fostering the right "attitudes and understandings" of psychiatric nursing. It should find a place as a text or reference in psychiatric nursing in every school of nursing.

The Story of Menstruation

Over a period of the last two years, Walt Disney Productions in Hollywood have prepared a new educational movie for teen-age girls entitled "The Story of Menstruation." This sound film, using the medium of beautifully colored animation, accomplishes the extraordinary feat of teaching something essentially serious while preserving an air of good cheer by relieving the tension with unexpected humor.

This film has been built around the reasoning that substituting accurate knowledge for fear and mystery will help to create a healthy attitude towards menstruation. It is expected to banish girl-to-girl superstitions and misconceptions, and should serve to minimize the mental handicap which hampers many girls during this period. The idea of a natural and normal cycle of life is constantly stressed in the film.

Great care was taken with the choice of a narrator for "The Story of Menstruation" and a woman was finally decided upon. The reason for this choice lies in the fact that the voice, of necessity, should not call attention to itself by being too good or too bad; too glib or too amateurish. It had to take the part of a "big-sister."

The making of this film posed many difficult problems. Animation was, of course, a happy solution to most of these. A half-real and half-diagramatic rendering of the "glass-figure" technique was employed to show the internal organs. Medical language was simplified and unnecessary terms eliminated without a loss of essential accuracy. A gynecologist of the highest reputation checked the story in detail at every stage of its development; words, pictorial representation, animation and implications.

16 mm., 10 minutes long, in sound and in color, this film is available to educational institutions. Bookings for "The Story of Menstruation" will be handled by The Canadian Cellucotton Products Company, Limited, 330 University Avenue, Toronto 1, Ontario.

Nearly Halfway There!

Slowly, the total of the War Memorial Trust Fund is rising. The necessity of getting copy to the printer early means that the most recent figures were assembled the end of October. They indicate some successes. Manitoba has passed its quota. Five other provinces show gains. In the remaining three, there has been no change since the last report. What new efforts have been made to reach the original objective? Will it be necessary to extend the closing date beyond this year?

The question has been asked: Why was such a large sum set as the objective? In arriving at the provincial quotas, the War Memorial Committee based the amounts on a donation of one dollar from each graduate nurse who was a paid-up member of her provincial association. The assigned quotas did not take into account the thousands of student nurses. Their solicitude for their fellow students has shown itself in contributions of food and clothing. They know how impossible it would be for them to study themselves had they no textbooks, no models, no visual aids. Have they been asked to help here?

The quotas did not provide for the thousands of married or retired nurses who no longer have active membership. Many of them have given most generously of their time and effort to meet staffing needs in our hospitals and public health organizations. They are ready and willing to assist with other worthwhile projects, such as this Memorial Book Fund, when they are informed about them.

The last figures show that we have reached 44 per cent of the quota. Here is the present standing, those showing an increase being starred:

Province	*Amount Collected*	*Per cent of Objective*
Manitoba	$2,161	108.0*
Alberta	1,798	89.9*
New Brunswick	679	75.5
Ontario	5,326	53.3*
Saskatchewan	744	46.5
Nova Scotia	661	41.3*
Prince Edward Island	80	40.0
British Columbia	1,307	35.3*
Quebec	1,313	13.1*
Other gifts	16	—
	$14,085	44.1

University Training

Most recent figures show that a total of 50,600 veterans have received assistance in their university courses by way of payment of fees and living allowance. The record of these young veterans has been outstanding. The percentage of failure has been small and reports from the universities across Canada show that a very large proportion of scholarships and prizes have been won by ex-service men and women.

Nursing Sisters' Association

The *Calgary Unit* is again able to report an active and successful year during 1947 with Mrs. S. S. Nelson as president. There is a membership of 65 with meetings held once a month that have been very well attended.

A quilt and parcels have been sent to an ex-nurse of St. Thomas's Hospital, London, Eng., as well as food parcels being forwarded to this hospital for distribution by the matron. Food and clothing have been received by a Dutch nurse. Subscriptions for the *Geographical Journal* were sent to the D.V.A. Hospital and to the Veteran Convalescent Home. Red Cross war service pins were presented to a number of nursing sisters by Mrs. H. C. Ironside. A contribution was made by the association and individual members to the C.N.A. War Memorial Fund.

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Memorial Vesper Services were held during May and a rummage sale in April netted $90. One held in October was in aid of the Parcels Fund. Five hundred dollars is maintained as an Emergency Fund.

The June meeting was in the form of a garden party at the home of Mrs. J. T. Gray. The members assisted with floral arrangements for the Remembrance Day celebrations and the Armistice Day tea was held at the Palliser Hotel. Members also assisted with the sale of poppies. A pre-Christmas meeting will be held at the Col. Belcher Hospital with Miss L. Pearson, an exchange teacher, as guest speaker.

Canadian Red Cross

The following are recent staff changes in the Provincial Divisions of the Canadian Red Cross Society:

British Columbia: APPOINTMENTS—*Isobel Whitaker* (Kitchener-Waterloo Hospital) as matron and *Katherine McKim*, from the R.C.A.M.C., to McBride outpost hospital; *Janet M. Card* (Clifton Springs, New York), matron, Kyuquot outpost; *Doris T. McPherson* (Toronto Western Hospital), matron, *Eleanor. M. Coulter* (Toronto Western Hospital), *Luella C. Brooks* (Prince Rupert General Hospital), and *Marjorie C. Doll* (St. Joseph's Hospital) to newly-opened 10-bed outpost hospital, Terrace, B.C. RESIGNATIONS—*Gladys Keilty*, matron, McBride outpost hospital, to be married; *Jennie Stremecki* from McBride outpost.

New Brunswick: APPOINTMENTS — The Tobique Valley Hospital, Plaster Rock, was opened recently with the following staff: *M. A. Cooney* (St. Michael's Hospital) as superintendent, *Mary Stymiest* (Soldiers' Memorial Hospital), *Ruby Glencross* (Soldiers' Memorial Hospital), *Alice Farquhar* (Fisher Memorial Hospital). *Florence Keswick* relieved *Harriet Hughes* (Ottawa Civic Hospital) during a leave of absence and has now returned to Kingston Hall Community Hospital. *Greta Rubins* (Saint John General Hospital), *Laura Tomilson* (Montreal General Hospital), and *Hazel Salmon* (Montreal General Hospital) served as relief nurses during vacations. *Christina Harvey* (Chipman Memorial Hospital) is now with the Grand Manan outpost hospital.

Nova Scotia: APPOINTMENTS — *M. Jean*

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McInnis, assistant supervisor, Outpost Hospital Service, Nova Scotia Division; *Shirley M. Beck*, charge nurse, South Cumberland Memorial Hospital, Parrsboro.

Ontario: APPOINTMENTS—*Juliette Fortin* (McGill University public health course), field organizer, Department of Volunteer Nursing Services; *Muriel Hay, B.Sc.N.* (Victoria Hospital, London, and University of Western Ontario public health course) and *Pauline McNee* (Toronto General Hospital and University of Toronto public health course), field organizers, Junior Red Cross; *Pearl A. Merriam* (Victoria Hospital, London, and University of Western Ontario), in charge at Port Loring outpost hospital; *Margaret Chattoe* (Royal Victoria Hospital, Montreal, and University of Western Ontario), Wilberforce; *Mary Cutler* (St. Michael's Hospital, Toronto), Dryden; *Bernadette McGarity* (St. Michael's Hospital, Toronto), Rainy River; *Mrs. Margaret Morrow* (Victoria Hospital, Winnipeg), Red Lake; *Kathleen Stanford* (Kitchener-Waterloo Hospital), Hawk Junction; *Dorothy Hall* (Victoria Hospital, London), charge nurse, Hawk Junction; *Dorothy Claridge*, nursing assistant, Nakina; *Lloydia Orr* (Toronto Western Hospital) and *Elsie Jenner* (Chatham General Hospital), Beardmore; *Vera Card*, Apsley; *Barbara Cox*, Kakabeka Falls. *E. Stronach*, an English nurse, flew out from England to join the staff at Thessalon.

RESIGNATIONS: *Grace McNaughton* and *B. Viney* from Richard's Landing; *Catherine Real* from Hawk Junction, *Margaret McNaughton* from Espanola, and *Vivian Goodreau* from Hornepayne, all to be married; *Irene Day* from Atikokan.

TRANSFERS AND RELIEF: *Betty Chinn* (Royal Alexandra Hospital, Edmonton, and University of Alberta) returned to Queen's University to continue her medical course after relieving at Bancroft for the summer. *E. Stephenson* and *Miss Rees*, English nurses who came to Canada to take a year's course at the University of Toronto, relieved in outposts at Christmas time and, following the closing of the university year, worked their way to Vancouver. On their return they stopped off at Dryden and did floor duty there for three weeks before sailing for England. *Mary Anderson* (Torbay Hospital, Eng.) from Hawk Junction to Lion's Head. *Mrs. Russell (Wright) Hawk* did charge duty at Dryden during the summer. *Mrs. Marjory (Foy) Beveridge* returned to Thessalon for the summer. Temporary relief at Bracebridge was given by *Dorothy Marshall* and *Olga D'arbasie* from Trinidad. *Mrs. Jean* (*Mason*) *Shouldice* and *Mrs. Margaret Shouldice* at Lion's Head. *Mrs. Porter* is now at Whitney. *Marjory Rilett* is taking the public health course at University of Toronto. *Ruth Boskill*, Port Loring, and *Elsie Turner*, Wilberforce, are taking the public health course at the University of Toronto on Red Cross scholarships. *Betty McIntosh*, Lion's Head, is also at the University of Toronto. *Barbara Easton* is at Nakina for two months. *Mabel Easton* has returned to New Liskeard after sick leave. *Elaine Read*, from Kakabeka Falls, is now public health nurse at Mindemoya following *Mrs. Jean Noble*.

Quebec: APPOINTMENTS — *Catherine Keith*, Barachois outpost, Gaspé; *Mary M. LeBlanc*, Douglastown outpost, Gaspé; *Germaine Doiron*, Grand Entrée outpost, Magdalen Islands. RESIGNATIONS—*Mrs. Muriel Schonberg* from Entry Island outpost, Magdalen Islands. TRANSFERS—*Elaine Corbett* has resigned from Barachois outpost to become director, Home Nursing, Montreal Branch.

Saskatchewan: APPOINTMENTS — *Mary Donoghue*, who has been with the Ontario Outpost Hospital Service, is now supervisor, Outpost Hospitals, replacing *Jean Nichol*. *Frances Robertson* and *Marion Williamson* (Victoria Hospital, Prince Albert), Hudson Bay; *Patricia Cunning* and *Dilys Evans* (Regina General Hospital), Loon Lake; *Mary Lyons*, on loan from Provincial Department of Public Health, charge nurse, Buffalo Narrows; *Freda Kelm* (St. Paul's Hospital, Saskatoon), supervisor, Regina Branch, Mothers' Milk Service Department. TRANSFERS—*Marion Roebuck*, nurse-in-charge from Hudson Bay to Stony Rapids; *L. Newell*, nurse-in-charge from Leoville to Hudson Bay; *E. Hockeley* in charge at Leoville.

News Notes

BRITISH COLUMBIA

KAMLOOPS-OKANAGAN DISTRICT:

"Charting a Course in Nursing" was the subject on which Gertrude Hall spoke at a largely attended dinner meeting of the Kamloops-Okanagan District, R.N.A.B.C., held in Kamloops. Miss Hall, who is general secretary of the Canadian Nurses' Associa-

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tion, gave inspiration and guidance as she outlined projects and problems in nursing today.

At the business meeting it was stated that $20 would be contributed towards the War Memorial Fund. Interesting reports and financial statements were given by the chapter delegates — Mrs. M. G. Rolph, Kelowna; Edna Williamson, Vernon; Mrs. E. Ransome, Kamloops; Norma Tucker, Princeton.

Returned to office were Mrs. M. Pigeau as president and Mrs. A. Mason, secretary-treasurer. Elected were: Public health section, F. Primeau; hospitals and schools of nursing, M. Humphreys; private duty and general nursing, Edna Williamson.

TRAIL:

At a meeting of Trail Chapter, R.N.A.B.C., it was revealed that a satisfactory sum was realized from the recent rummage sale. Donations were made to aid a nurse who is confined in the tuberculosis unit in Vancouver. After adjournment, the members listened to the broadcast by the local medical health officer, Dr. J. S. Daly, and his introduction of the public health nurses to the city of Trail and district. Three new members were welcomed to the chapter.

MANITOBA

BRANDON:

Marion Patterson, president of the Brandon Graduate Nurses' Association, was in the chair at a recent meeting. After a short business discussion the executive were hostesses at a friendly hour which was thoroughly enjoyed as graduates renewed old acquaintances and made welcome several new members.

NEW BRUNSWICK

SAINT JOHN:

At a recent well-attended meeting of Saint John Chapter, N.B.A.R.N., plans were made for a "Bring and Buy" sale, the object being to help bring the N.B. quota for the War Memorial Fund up to 100 per cent. A letter of appreciation for blankets and a quilt, given to the Rest-Breaks Home in England, was read. Dr. Earle Grant was the guest speaker and his talk on "Plastic Surgery" was very interesting and informative.

The General Nursing Section realized $128 which was given to the local registry toward expenses.

Dorothy Fullerton was elected president of the Public Health Section at their recent annual meeting. Gertrude Burast and Constance Swinton, who are now on the V.O.N. staff, were welcomed as new members. Parcels for overseas are still being sent regularly.

General Hospital:

At a meeting of the Saint John General Hospital Alumnae Association Mrs. Handren and Hazel Tracey gave a report of the N.B. A.R.N. annual meeting. An interesting talk by Florence Lamb on her "Return Trip to Oslo" was also heard. A gift of ten dollars was given to St. Mary's Church toward the expense of its new chimes. Miss Tracey placed the wreath on the Cenotaph on Remembrance Day.

An enjoyable event was the annual autumn dance given by the student body. Receiving the guests were Miss Murdoch and Miss Peters. Norna Tedlie was the able convener, assisted by Misses Grass, Estey, Higgs, Allison, and Sandford.

The junior nurses recently entertained the probationers when games were enjoyed and refreshments served. The committee of arrangements consisted of Dallas Robertson, Pauline Grass, Charleen Farmham, Norena Clarke, Barbara Baker, and Irene Powe. Misses Peters, Myers, Bell, and Hanscome represented the staff.

Ethel Reid is now on the teaching staff at Flushing Hospital, N.Y. Edyth Hunter, a Hartford Hospital (Conn.) graduate, has joined the surgery department. Kay Kincade, of Vancouver, is visiting Saint John for the winter.

Lancaster Hospital:

The Lancaster Nurses' Association entertained at tea in honor of five members of the staff — two recent brides, two about to be married, and one who is leaving the staff to further her studies. The honor guests were Mmes D. Fitzpatrick and R. Martin, Misses Jean Guild and M. Parks, brides-elect, and Margaret McJunkin. Mrs. Fitzpatrick was the recipient of a wall mirror, Mrs. Martin a gift of linen, Miss Guild a lamp, Miss Parks a serving tray, and Miss McJunkin a compact. The tea table was presided over by the matron, Edna Dixon.

St. Joseph's Hospital:

Sr. M. Michael has gone to Prince Albert, Sask., to take charge of the orphanage. Sr. Theresa Carmel has returned to the staff after spending some time in western Canada. Sr. M. Joseph is supervisor, 2nd floor. Martina Carey is now on the staff. Elizabeth Wood resigned to be married. Frances Dionne has left the staff for Vancouver. Laura Harper is now at the Moncton Hospital.

NOVA SCOTIA

HALIFAX:

Children's Hospital:

Mrs. J. T. Luscombe and members of the committee of the Nurses' Official Directory recently entertained at a tea at the Sword and Anchor Inn in honor of Marjorie Jenkins, who resigned as superintendent of nurses.

Victoria General Hospital:

Mrs. J. T. Luscombe was in the chair at the first fall meeting of the alumnae association when 35 members attended. The association has been very active during the

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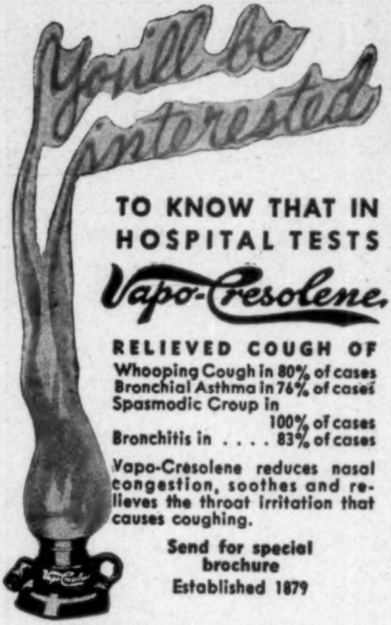

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ROUGIER FRÈRES - MONTREAL

past months, food and clothing having been sent regularly to a needy English nurse. Mrs. H. S. T. Williams, treasurer, is the convener of this work.

A delightful tea was held in honor of the 1947 graduating class when the president, Mrs. Luscombe, and the vice-president, Dorothy Gill, received the 65 guests. Anna Brennan and Miriam Ripley presided at the tea table, assisted by several members.

ONTARIO

DISTRICT 1

LONDON:

The Community Nursing Registry recently sponsored a series of lectures when several interesting speakers were heard. Included on the program were the following:

Associate services: Mildred Walker, University of Western Ontario (Broad aspect of public health); Dorothy Mickleborough, National Office Supervisor, Victorian Order of Nurses; Florence Christie (Family service bureau). These lectures were given to acquaint the nurses with the various organizations available to their patients and how these organizations are involved when illness occurs. Legal Hazards in Nursing — Mr. A. B. Siskind, barrister. New Drugs — Dr. J. H. Geddes. After Care of Accident Cases — Dr. R. A. Johnston. Personality Studies in the Nursing Field — Dr. G. H. Stevenson. Physical Medicine and Rehabilitation — Dr. T. H. Coffey.

Mildred Walker, faculty member, School of Nursing, University of Western Ontario, has returned from Teachers College, Columbia University, where she received her M.A. degree in personnel, administration and guidance.

WINDSOR:

The Hotel Dieu Alumnae Association has made the following contributions: War Memorial Fund, $50; Canadian National Institute for the Blind, $100.

DISTRICTS 2 AND 3

ELORA:

St. John's Anglican Church, in which the innovation of a special service for nurses was instituted last year, welcomed approximately 250 nurses at a recent Sunday night service. As well as nurses from the immediate district, also in attendance were representatives from the hospitals of Fergus, Owen Sound, Guelph, Kitchener, Brantford, Stratford, Galt, and Woodstock.

In welcoming them the rector, Rev. C. J. Loat, explained the purpose of the service, which was to link this church, which treasured its association with Florence Nightingale, with the annual Sunday dedicated by the nurses in Canada for church service. With this in mind there had been worked into the new decoration of the church, the indistinct figure of a nurse, just over the niche in which the Nightingale Communion Service has been placed and it is hoped that the importance of this noble profession may be kept in the minds of all those who are drawn by their interest in things religious and historical to visit this village church.

Mr. Loat told the story of a woman who devoted her life in learning to care for the sick, and the man whom she was forbidden to marry and who found fulfilment in a mission to the Canadian Indians, afterwards becoming the first resident incumbent of the parish of St. John in Elora. The presentation of a set of communion silver, on her behalf to him and to this church, has linked this Ontario village with a page of vitally important history and it is with this in mind that the annual service has been undertaken.

DISTRICT 4

NIAGARA FALLS:

At the first meeting of the season of District 4, R.N.A.O., Anna Oram, the chairman, presided. She presented an interesting report of the activities since the last meeting. Catharine O'Farrell, of Niagara Falls, presented the War Memorial Committee report and the secretary-treasurer of the district, Irene Lawson, reported on the I.C.N. Congress. The guest speaker, Dr. A. B. Whytock, gave an informative address, touching on the highlights of scientific research in the world of today with reference to the atomic age. Dr. Whytock was thanked by M. Blackwood of Hamilton. Vocal selections by Mrs. W. Marshall, accompanied at the piano by Mrs. E. B. Merrifield, were enjoyed. Constance Brewster, superintendent of nurses at the Hamilton General Hospital, extended a vote of thanks to the committee in charge of arrangements.

HAMILTON:

The first fall meeting of Hamilton Chapter, District 4, R.N.A.O., was held at McMaster University with Mary E. Blackwood in the chair. Arrangements were made to have this chapter disbanded at the end of the year and the district made responsible for the activities and meetings in Hamilton. Due to war conditions and transportation difficulties, the district was divided into two chapters in 1942.

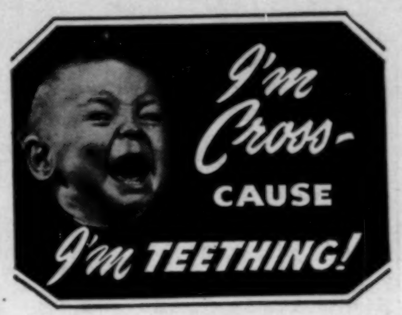
Annette Allison was guest speaker at this meeting. She is a nutritionist with the Hamilton Branch of the V.O.N. Her talk on "Nutrition" and the two films presented were greatly enjoyed by the members.

Seven food parcels are sent to Britain every month and many "Thank You" letters have been received. To increase the chapter's contribution to the British Nurses Relief Fund a Hallowe'en party was held.

DISTRICT 5

ALLISTON:

A tour of the Stevens Memorial Hospital was part of the program of the recent meeting of District 5, R.N.A.O. Mr. Marshall Close, of Toronto, spoke at the dinner, when his subject was "The Power of Words."



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QUEBEC

MONTREAL:

McGill School for Graduate Nurses:

For the first fall term, the McGill School for Graduate Nurses opened in its new home at 1266 Pine Ave. West, the Beatty Memorial Residence. There are 116 students, representing six certificate and four degree groups. The largest representation, as in other years, is in public health, with approximately seventy nursing sisters included in the whole group.

A new senior staff appointment is Miss Eugenie Stuart, who has recently completed her degree in hospital administration at Northwestern University, Chicago. (See Nursing Profiles, this issue.) Included on the staff this year as well are two teaching fellows — Margaret Holder (P.H., 1943) and Ruth MacPherson (Cert. in psych. nursing, 1947). They are continuing with studies toward their degrees and doing part-time work in the school.

Miss Lindeburgh is still seeking additional staff members to meet the expanding programs. One special development of note in the past two years has been the establishment of advanced clinical nursing courses in psychiatry and obstetrics. This year the field of pediatric nursing is being analyzed in order to provide an advanced clinical course in this work for the next year's session.

Clara Aitkenhead (T. & S., 1939) has resigned as nursing arts instructor at the Homoeopathic Hospital, Montreal, and has returned to her own school, the Montreal General Hospital, as head nurse, Ward C. Floranna Bryant (T. & S., 1947) has replaced Miss Aitkenhead at the Homoeopathic. Dorothy Mapes (T. & S., 1947) is at the same hospital as science instructor. Alice Gage (T. & S., 1941), who has been on the staff of the V.O.N. central office in Montreal, is attending Columbia University. Mildred Brogan (T. & S., 1944) has resigned from the teaching staff, Montreal General Hospital, and is now with Crane & Co. Elva Honey (B.N. Admins., 1947) is second assistant to director of nursing, Montreal General Hospital. Louise Bartsch (B.N. Admins., 1947) is the assistant superintendent of nurses, Royal Edward Laurentian Hospital, Ste. Agathe des Monts, P.Q. Edna Felsing (T. & S., 1943) has resigned from the teaching staff at the Children's Memorial Hospital, Montreal, and is now at the Sherbrooke Hospital as instructor. Ann Peverley (P.H., 1935) attended summer school, Teachers College, Columbia University. Mary Harling (T. & S., 1943) is back at the school this year completing her B.N. in teaching. Moyra Allen (T. & S., 1946) is also completing the same course, after a year's teaching at Saskatoon City Hospital.

The following graduates of T. &. S, 1947, have returned to the Royal Victoria Hospital, Montreal: Maud Dolphin as head nurse, pediatric ward; Edith Pratt, head nurse, women's medical; Bea Allen, instructor, teaching department. Jean Thirlaway (B.N. in teaching, 1947) is head nurse on ear, nose and throat ward. Clara Cook (T. & S., 1947) is night supervisor in the main building of R.V.H. Emma Scott (Cert. in obstet. nursing, 1947) has returned to teaching staff of the R.V. Montreal Maternity Hospital. Cecilia Pope (P.H., 1940) is doing private duty in Moncton. Mary Rowles (T. & S., 1937) is doing industrial nursing at the Dominion Glass Co., Redcliff, Alta. Mary (Toner) Barrett (T. & S., 1944) is doing part-time teaching at St. Mary's Hospital, Montreal. Estelle (Tritt) Aspler (T. & S., 1947) is assistant instructor, Herbert Reddy Memorial Hospital, Montreal.

Royal Victoria Hospital:

Reports from several members who attended the I.C.N. Congress were heard at a recent meeting of the alumnae association. A mass meeting of the student nurses was addressed by Mrs. E. Fleming regarding subscriptions to *The Canadian Nurse* and the promotion of the magazine. An interesting film on "Oxygen Technique" was shown to the interne and nursing staff by the Dominion Oxygen Co.

Staff nurses have been endeavoring to raise funds in support of the War Memorial Fund for the purchase of books for school of nursing libraries in countries devastated by the war. Included in these activities have been an enjoyable bridge at which W. MacLean entertained and a successful "hot dog" sale under the capable management of Helene Lamont.

E. Hirsch is now head nurse, Ward G, with J. Northcote as her assistant.

SASKATCHEWAN

MOOSE JAW:

General Hospital:

Shirley Rhodes is now superintendent of nurses at Bengough Hospital. Audrey Miller is supervisor of the children's ward, M. J. G. H. Mr. and Mrs. E. Walter Greenwood are now living in Saskatoon.

Sniffly Nostrils

CLEAR HEAD AND NOSE

Mentholatum quickly helps to clear choked nasal passages. It relieves the most aggravating head cold. Jars and tubes, 30c. V-3

MENTHOLATUM
Gives COMFORT *Daily*

I was brought up on them myself

Many nurses and doctors, too, as well as persons in all walks of life owe a debt of gratitude to Baby's Own Tablets for the comfort these simple triturates brought to their own babyhood upsets. Yes, over half a century of successful use have proved the dependability of Baby's Own Tablets for relief of constipation, digestive upsets, teething troubles and other minor ills.

Mild, tasteless with little or no disturbing side reactions Baby's Own Tablets provide a most efficient and pleasant laxative for infants up to 3 years of age.

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Easy to put on, hard to rub off . . . 2 IN 1 White is a special help to nurses . . . keeps all kinds of white shoes whiter . . . helps preserve leather.

2 IN 1 WHITE

2 in 1
WHITE CLEANER

TRY LAVORIS

One Trial Will
Convince You

It keeps mouth and breath clean and sweet

NORTH BATTLEFORD:

The S.R.N.A. is pleased to welcome another chapter at North Battleford, District 1. The following officers have been elected: Honorary president, Sr. Superior Mary de Loyola; president, Mrs. Pauline Baldwin; vice-presidents, Mrs. M. Nutting, Mary Orr; secretary-treasurer, Lois Boyd; section conveners: hospital and school of nursing, Rev. Sr. Therese Amable; general nursing, Mrs. G. H. Orr; public health, Mrs. N. MacDonald. The chapter, now being part of the S.R.N.A., will be able to avail itself of the educational and social privileges offered by that organization. Part of the work of chapters is assisting with community efforts and the new chapter has decided to furnish a room in the new wing of the hospital.

REGINA:

The Regina Chapter, S.R.N.A., was pleased to have K. W. Ellis, provincial association registrar, in attendance at a recent meeting.

General Hospital:

Emily Robinson is now on the nursing staff and Ruth Boughen is on the psychopathic ward staff.

Grace Haven:

Major Mae Taylor, formerly of Vancouver, successor to Major Mabel Cosway, as matron, was welcomed to Regina at the first meeting of the fall season of Grace Haven auxiliary.

Grey Nuns' Hospital:

A recent meeting of the alumnae association took the form of a supper, when Dr. Fitzgerald spoke on "Psychiatry." Rev. Srs. Brodeur and Daveneau attended the October meeting of the Canadian Hospital Council held in Winnipeg and Srs. Superior Farley and Reome were present at the Saskatchewan Hospital Association convention held at Saskatoon.

SASKATOON:

The Saskatoon Chapter, S.R.N.A., met at St. Paul's Hospital to hear a talk by Mr. Wood of the Saskatoon Public Library.

City Hospital:

M. Chisholm, who recently returned from Ottawa and eastern points, gave a few interesting highlights of her trip at a regular meeting of the alumnae association.

Joan Witney, B.Sc.N., was a visitor to Saskatoon from Norway House, Man., prior to her departure for Kingston where she will study medicine. Mrs. J. Porteous attended the hospital convention held at Edmonton. Appointments to the general duty staff include: Mary (Cosford) Levers, Lillian (Lasser) Newbert, Mrs. A. E. (Bunkowsky) Jasechko, Misses E. M. Toovey, Blakely, Riske, and Waiser. A. Meadows, M. Jarvis, and W. Routledge have resigned from the staff. Prior to their departure, social evenings were held by the Graduate Society and the Student Nurses' Association when appropriate gifts were presented to the departing nurses.

St. Paul's Hospital:

M. Quigley, a University of Saskatchewan graduate, is now assistant dietitian. Margaret Skarsgard replaces L. DeFaye who resigned after four years in the operating-room. Srs. Superior, Mandin, and Morin attended an interesting institute on administration in Edmonton. L. Brown has left for Montreal.

Elizabeth Smith, director of nursing services, Saskatchewan Department of Public Health, recently spoke to the third-year students.

YORKTON:

Ethel James has resigned as instructor of nurses at the General Hospital and is now instructor at Regina General Hospital. Myrtle E. Crawford has replaced Miss James, with Joanne Gorchinsky as her assistant. Linda Long has been appointed assistant superintendent at the Y.G.H.

Betty Langstaff has returned from taking a course at McGill University and has taken up duties as rural district public health nurse for Yorkton, replacing Miss Gorchinsky. Mary R. Chisholm and Mary Edwards, supervisor in the Saskatchewan Department of Public Health, were recent visitors to the city. K. Francis and V. Ostapovitch attended the hospital convention held in Saskatoon.

Positions Vacant

Superintendent of Nurses for 100-bed General Hospital, with Training School, in Western Ontario. Apply, stating qualifications, experience, and date available, to Administrator, General Hospital, Woodstock, Ont.

Instructor of Nurses or Clinical Supervisor. Apply to Supt., Royal Victoria Hospital, Barrie, Ont.

Night Supervisor for 50-bed Maternity Hospital. Apply, stating qualifications, salary, etc., to Supt., Catherine Booth Mothers' Hospital, 4400 Walkley Ave., Montreal 28, P.Q.

General Staff Nurses at $140 per month living out, plus laundry. **Operating-Room and Recovery Room Nurses** (Post-Graduate course essential) at $145 per month living out, plus laundry. Annual increment, accumulative sick leave, hospitalization, superannuation, 31 days' vacation, statutory holidays, 8-hour day and 6-day week. State in first letter date of graduation, experience, references, etc., when services would be available, and whether eligible for registration in British Columbia. Apply to Director of Nursing, Vancouver General Hospital, Vancouver, B.C.

General Staff Nurses (Registered). Initial salary: $76.20 bi-weekly. Increment at the end of 1st and 2nd years of service. 3 weeks' annual vacation. 6-day (48-hour) week. Sick leave — 1 day per month — accumulative. Pension Plan. Excellent living accommodation. Apply to Supt. of Nurses, Toronto Hospital for the Treatment of Tuberculosis, Weston, Ont.

General Duty Nurses for 200-bed General Hospital in Niagara Peninsula. Salary: $110 per month plus full maintenance. 48-hour week, straight shift. Railway fare will be refunded after 6 months' satisfactory service. Apply to M. McComb, Supt., County General Hospital, Welland, Ont.

Registered Nurses (2) for **Floor Duty** in small hospital. 8-hour day and 6-day week. 4 weeks' vacation. 2 weeks' sick leave. Attractive residence. Apply to Supt., Niagara Cottage Hospital, Niagara-on-the-Lake, Ont.

Graduate, Registered Nurse for **Floor Duty** by January 1. Salary: $100 per month; full maintenance; increase of $5.00 per month after 1 year's service, up to 3 years. 8-hour duty. Blue Cross Hospitalization. Apply to Supt., Barrie Memorial Hospital, Ormstown, P.Q.

Registered Nurses (2) for **General Duty** in 23-bed hospital located in Southern Interior of British Columbia near U.S. border. 2 active surgeons on staff. Gross salary: $140 per month. 1 month vacation per year with pay. Popular lakeside summer resort nearby. Apply to Sec., Community Hospital, Grand Forks, B.C.

Qualified Dietitian for General Hospital. Good salary and full maintenance. Apply to Administrator, General & Marine Hospital, Owen Sound, Ont.

Nursery Supervisor with post-graduate experience. Apply, stating qualifications and experience, to Supt. of Nurses, General & Marine Hospital, Owen Sound, Ont.

Matron. Salary: $150 per month plus maintenance. **Graduate Nurses** (2). Salary: $120 per month plus maintenance. 16-bed hospital. Apply to Municipal Hospital, Magrath, Alta.

Public Health Nurses. Minimum salary: $2,000 with provision for annual increases to $2,700. 3 weeks' vacation with pay; pension plan; car provided. Qualifications: Preferably not over 35 years of age; public health training; public health experience; special orthopedic training if possible. If the latter is not considered sufficient, a 6-month in-service training will be given at slightly reduced salary. Apply to Director of Nurses, Ontario Society for Crippled Children, 112 College St., Toronto 2, Ont.

Graduate Nurses for **General Duty** in 350-bed **Tuberculosis** Hospital. Salary: $110 per month plus full maintenance, with yearly increments of $5.00 a month to a maximum of $125. 6-day week with 6 hours of duty on Sunday. Good living conditions. Apply to Supt. of Nurses, Royal Edward Laurentian Hospital, Ste. Agathe des Monts, P.Q.

Matron for 70-bed hospital in Southern Okanagan. Salary: $190 per month less $30 for suite and board. Apply, stating qualifications, references, age, and experience, to Supt., Penticton Hospital, Penticton, B.C.

Teaching Staff is now being engaged for the **C.N.A. Demonstration School of Nursing.** Instructors who are interested should write for further information, stating qualifications, to the Metropolitan School of Nursing, 849 Kildare Rd., Windsor, Ont.

WANTED — 2 INSTRUCTORS

(a)Nursing Science Instructor, for *January 1, 1948.*

(b) Nursing Arts Instructor for *July 1, 1948.*

For a large hospital in Southern Ontario, with approximately 275 Student Nurses. Applications should be addressed in care of:

Box 9, The Canadian Nurse, Ste. 522, 1538 Sherbrooke St. W.,
Montreal 25, P.Q.

Licensed Nurses for **General Duty** in small General Hospital in an attractive community, 50 miles from Ottawa. Salary: $105 per month Day Duty with full maintenance; $115 per month Night Duty with full maintenance. Apply to Supt., Pontiac Community Hospital, Shawville, P.Q.

General Duty Nurses for 80-bed General Hospital in Southern Ontario. Salary: $115 per month (including pay for O.R. call and bonus), plus maintenance. Increase at end of 6 months to $120 and at end of 1 year to $125. 8-hour day and 6-day week. 2 weeks' holiday with pay (3 weeks given at end of 2nd year). Allowance for sick leave, hospitalization, and statutory holidays. Additional $5.00 per month paid for 3:30 shift. Apply, stating qualifications and date available, in care of Box 8, The Canadian Nurse, Ste. 522, 1538 Sherbrooke St. W., Montreal 25, P.Q.

Registered Nurse for **Ward Supervision.** Salary: $135 per month plus maintenance. **Graduate Nurses (2)** for **General Duty.** Salary: $115 per month plus maintenance. 8-hour day and 6-day week. Apply to Supt. of Nurses, Fort William Sanatorium, Fort William, Ont.

Public Health Nurse for Generalized Public Health Nursing Service. Must be bilingual (French & English). Apply to Supervisor, Public Health Nursing, Prescott & Russell Health Unit, Hawkesbury, Ont.

Superintendent of Nursing for the Parry Sound General Hospital, Parry Sound, Ont. Bed capacity: 75 adult and 18 nursery. Apply in writing or in person, stating qualifications and salary expected, to the Chairman, Board of Directors, General Hospital, Parry Sound, Ont.

Early Chinese Medicine

The Chinese people are famous, among other qualities, for their love of order and nothing in the history of Chinese medicine is perhaps more remarkable than the high degree of practical organization which existed side by side with extremely artificial medical theories during the Chou dynasty. The Chou Rituals describe four kinds of doctors, each with his special well-defined sphere. First there is the dietitian to look after food and drink; second the physician, concerned with internal complaints only; third the surgeon, whose sphere is external diseases such as wounds, fractures and ulcers; and lastly the veterinary surgeon to care for sick animals.

You will note that the dietitian comes first in this classification, and this is the place he occupies in the scheme of organization of the medical department. His function is defined very exactly as that of mixing the six foods and drinks, the six meals, the hundred sauces, and the eight delicacies to see that each is of the right taste and consistency.

At this period, in spite of the fact that the priest and physician were already separate, there was still general distrust of the latter's ability and character.

The Analects says that without perseverance one cannot even become a doctor and the Record of Rates warns against taking any medicine compounded by a doctor who has not the experience of three generations behind him; an attitude of caution shared by no less a person than the great Confucius who, on being sent a present of medicine by a disciple, received it with a bow and the words, "I do not know it, I dare not taste it." The T'ang Annals class doctors with mathematicians, surveyors, fortune-tellers, physiognomists and magicians as charlatans. "The Sages," it says, "did not regard them as educated."

—*Proceedings of The Royal Society of Medicine.*

Official Directory

CANADIAN NURSES' ASSOCIATION

1411 Crescent St., Montreal 25, P.Q.

President	Miss Rae Chittick, Faculty of Education, University of Alberta, Calgary, Alta.
Past President	Miss Fanny Munroe, Royal Victoria Hospital, Montreal 2, P.Q.
First Vice-President	Miss Ethel Cryderman, V.O.N., 281 Sherbourne St., Toronto 2, Ont.
Second Vice-President	Miss Evelyn Mallory, University of British Columbia, Vancouver, B.C.
Third Vice-President	Miss Marion Myers, Saint John General Hospital, Saint John, N.B.
Honorary Secretary	Rev. Sister Denise Lefebvre, 1185 St. Matthew St., Montreal 25, P.Q.
Honorary Treasurer	Miss Lillian Pettigrew, Winnipeg General Hospital, Winnipeg, Man.

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Numerals indicate office held: (1) *President, Provincial Nurses Association;* (2) *Chairman, Committee on Institutional Nursing;* (3) *Chairman, Committee on Public Health Nursing;* (4) *Chairman, Committee on Private Duty Nursing.*

Alberta: (1) Miss B. Emerson, 23 Rene LeMarchand Mansions, Edmonton; (2) Miss A. Anderson, Royal Alexandra Hospital, Edmonton; (3) Miss G. Hutchings, Strathmore; (4) Miss Orma Smith, Galt Hospital, Lethbridge.

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Manitoba: (1) Miss I. Barton, Veterans' Home, Winnipeg; (2) Miss V. Williams, St. Boniface Hospital, 3) Miss D. Dick, City Health Dept., Winnipeg; (4) Miss M. Muir, 16 Gordon Apts., Winnipeg.

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EXECUTIVE OFFICERS

International Council of Nurses: 19 Queen's Gate, London S.W. 7, England. Acting Executive Secretary, Miss Virginia Arnold.

Canadian Nurses' Association: 1411 Crescent St., Montreal 25, P.Q. General Secretary, Miss Gertrude M. Hall. Assistant Secretary, Miss Winnifred Cooke.

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Registered Nurses' Ass'n of British Columbia: Miss Alice L. Wright, 1014 Vancouver Block, Vancouver.
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Registered Nurses' Ass'n of Nova Scotia: Miss Nancy Watson, 301 Barrington St., Halifax.
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District 1

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QUEBEC

The Association of Nurses of the Province of Quebec

The Association of Nurses of the Province of Quebec, created by Licensing Act, April 17, 1946, replacing The Registered Nurses Association of the Province of Quebec, Incorporated February 14, 1920.

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A.A., Cornwall General Hospital

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A.A., Ottawa General Hospital

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Children's Memorial Hospital, Montreal

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L'Association des Gardes-Malades Diplômées, Hôpital Notre-Dame, Montréal

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SASKATCHEWAN

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